REDACTED

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
HORACE MILANO MELLON, M.D. Physicians and Surgeons Certificate No. A-030748,	No. D-2641
Petitioner.	L-23655

ORDER DENYING RECONSIDERATION

The petition for reconsideration filed by respondent Horace M. Mellon, M.D. was considered and discussed by the Division of Medical Quality at its meeting in Anaheim, California on February 9, 1984.

The petition was denied and on February 28, 1984 an Order Denying Reconsideration was mailed. That order incorrectly stated the effective date of the revocation decision to be March 9, 1984.

The correct effective date of the revocation decision is now March 28, 1984 .

Dated: March 5, 1984

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By Vernon A. Leeper
Vernon A. Leeper

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

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ORDER DENYING RECONSIDERATION

The petition for reconsideration filed by respondent Horace M. Mellon, M.D. was considered and discussed by the Division of Medical Quality at its meeting in Anaheim, California on February 9, 1984.

The petition was denied.

The new effective date of the revocation decision is now March 9, 1984.

Dated February 28, 1984.

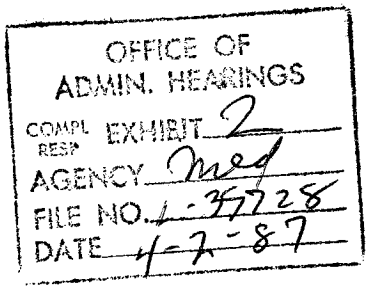
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By Vernon A. Leeper
Vernon A. Leeper

BOARD OF MEDICAL QUALITY ASSURANCE

DIVISION OF MEDICAL QUALITY

STATE OF CALIFORNIA



In the Matter of the Accusation Against:	)	NO. D-2641
HORACE M. MELLON, M.D. Certificate No. A-20748,	)	
Respondent.	)	

ORDER GRANTING STAY

IT IS ORDERED that the request for stay of execution of the decision effective October 12, 1983, is granted. Execution is stayed until November 11, 1983.

DATED: October 7, 1983

Diane Ford

DIANE FORD
Deputy Program Manager
Enforcement Program

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
BARRY SCOTT SOLOF, M.D. 2065 Outpost Drive Los Angeles, CA 90068	)	NO. D-2641 L-23655
Physician's and Surgeon's Certificate No. G-29239,	)	
and	)	
JACOB LOUIS FREIBRUN, M.D. 1016 Westholme Avenue Los ongeles, California 90024	)	
Physician's and Surgeon's Certificate No. A-6323	)	
and	)	
HORANCE MILANO MELLON, M.D. 401 West Manchester Boulevard Inglewood, California 90301	)	
Physician's and Surgeon's Certificate No. A-030748,	)	
Respondents.	)	

DECISION

The attached Proposed Decision is hereby adopted by the Board of Medical Quality Assurance as its decision in the above entitled matter.

This Decision shall become effective October 12, 1983.

IT IS SO ORDERED September 12, 1983.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
STATE OF CALIFORNIA

By _____
MILLER MEDEARIS, Secretary-Treasurer

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BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
BARRY SCOTT SOLOF, M.D. 2065 Outpost Drive Los Angeles, California 90068	NO. D-2641 L-23655
Physician's and Surgeon's Certificate No. G-29239,	
and	
JACOB LOUIS FREIBRUN, M.D. 1016 Westholme Avenue Los Angeles, California 90024	
Physician's and Surgeon's Certificate No. A-6323	
and	
HORACE MILANO MELLON, M.D. 401 West Manchester Boulevard Inglewood, California 90301	
Physician's and Surgeon's Certificate No. A-030748,	
Respondents.	

PROPOSED DECISION

This matter came on regularly for hearing before Robert A. Neher, Administrative Law Judge of the Office of Administrative Hearings, at Los Angeles, California on January 11, 12, 13, 14, 15, 18, 19, 20, 21 and 22, 1982, and thereafter on August 9, 10, 11, 12, 13, 16, 17, 19, 20, 23, 24, 25, 26, and 27, 1982, and on January 10, 11, 12, 13, 18, 19, 21 and 25, 1983, at various hours. William L. Carter, Deputy Attorney General, represented the complainant. Respondent Solof appeared in person and was represented by Ronald S. Marks, Attorney at Law. Richard Harding,

Attorney at Law, represented respondent Freibrun. Respondent Mellon failed to appear.

Due to the similarity of factual issues, this case was consolidated for hearing with case number L-24645 (No. 0-0041) before the Department of Health Services. Documentary and oral evidence was introduced, and the record left open for the parties to file written argument. On February 22, 1983, complainant's argument was received and marked as Exhibit 49, for identification only. On March 25, 1983, respondent's argument was received and marked as Exhibit N.N., for identification only. On April 1, 1983, complainant, by letter marked as Exhibit 50, for identification only moved that respondent's argument not be considered. On April 6, 1983, by letter marked as Exhibit O.O., for identification only, reply was made to complainant's motion. On April 12, 1983, by letter marked as Exhibit 51, for identification only, complainant responded to respondent's reply letter. Thereafter, the matter was deemed submitted. The Administrative Law Judge finds the following facts:

I

Robert G. Rowland made the Accusation in his official capacity as the Executive Director of the Board of Medical Quality Assurance.

II

On or about May 9, 1975, the Board issued to respondent Barry Scott Solof, M.D. physician's and surgeon's certificate number G-29239. Said certificate is now, and was at all times mentioned herein, in full force and effect.

III

On or about August 30, 1933, the Board issued to respondent Jacob Louis Freibrun, M.D. physician's and surgeon's certificate number A-6323. Said certificate was at all times mentioned herein, in full force and effect.

IV

On or about February 17, 1977, the Board issued to respondent Horace Milano Mellon, M.D. physician's and surgeon's certificate number A-30748. Said certificate is now, and was at all times mentioned herein, in full force and effect.

V

At all times mentioned herein respondent, and each of them worked at Victoria Medical Group, a clinic at 4449 West Adams Boulevard in Los Angeles. Respondent Solof was employed from and after May 1, 1977, and sometime in 1978 became the owner of the clinic, taking over totally on January 1, 1979.

Respondent Mellon was employed by the clinic from on or about July 1, 1978, until March of 1979. Respondent Freibrun was employed by the clinic from and after at least 1976.

VI

During the recess of this hearing between January 22, 1982 and August 9, 1982, respondent Freibrun passed away. The Accusation was dismissed as against said respondent personally and the findings made herein relating to him are made only to show the course of patient treatment as it relates to the other respondents and the physicians assistants.

VII

Leonard Washington and Hunter Vassar were and now are Physicians Assistants first licensed by the State on April 5, 1978, and April 27, 1978, respectively. Prior to that time they were working as Physicians Assistants pursuant to interim approvals. At all times mentioned herein Washington and Vassar were employed by the clinic. Solof and Freibrun were listed as the required supervision for Washington; and all three respondents were listed as the required supervision for Vassar.

VIII

FINDINGS RE PATIENT GW

(1) Patient GW, a 55-year-old female, was first seen at Victoria Medical Group by Vassar under Solof's supervision on or about December 5, 1977. The presenting complaints were arthritis, nervousness, insomnia for one month, and chest cold with productive yellow sputum for one week. GW was treated at the clinic 10 times between December, 1977, and July, 1978, by respondents Solof, Freibrun, and Mellon, or the Physicians Assistants.

(2) On her first visit to the clinic on or about December 8, 1977, GW stated that she had had gall bladder surgery 20 years in the past but respondents failed to determine and/or record any particulars with respect to said surgery, including the nature and location thereof, and failed to obtain surgery and pathology reports with respect to said surgery. It was not established by the evidence that gross negligence and/or incompetence in light of the natures of GW's presenting and subsequent complaints and symptoms, was committed.

(3) On her second visit to the clinic on or about December 15, 1977, GW complained of Pelvic pain and stated that she had had a hysterectomy in 1955. Respondents failed to obtain any documentation to establish the pathology for said surgery. It was not established by the evidence that this constituted gross negligence and/or incompetence.

(4) On her third visit to the clinic on or about January 10, 1978 GW was given a repeated pelvic examination including a papanicolau test and was given repeated electrocardiogram, urine analysis and culture and sensitivity testing although these tests had been performed previously on her first visit. Numerous examinations were performed over the course of GW's treatment by respondents. In spite of a reported estrogen effect as adequate or above normal on April 14 and 17, 1978, GW was given estrogen injections for "dysfunctional vaginal bleeding" or "hot flashes" on January 10, April 18, and May 2, 1978. The diagnosis of "dysfunctional bleeding" in a hysterectomized woman evidences negligence on the part of the physicians assistant, and the part of the physician for failure to correct the situation; but does not establish gross negligence and/or incompetence. It was not established the repeated testing and estrogen injections with respect thereto constitute repeated acts of clearly excess prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(5) As early as February 11, 1978, a urine analysis showed 11-20 WBC (white blood count) and 1-4 RBC (red blood count) on the high powered field. Urine culture and sensitivity tests were ordered repeatedly in the face of low WBC's and a shift to the right, which indicate a low probability of infection. It was not until July 12, 1978, that the source of the bleeding referenced hereinabove was found to be from the urinary tract. It was not established that X-ray evidence of abnormal pelvic calcification on or about April 10, 1978, was ignored by respondents. The patient was given a gynecology referral after the X-ray. It was not established that respondents' conduct in this regard constitutes gross negligence and/or incompetence and repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(6) On or about July 19, 1978, GW was hospitalized by respondent Mellon for gross hematuria. No cystoscopy was performed during GW's 3-day hospital dtay and a sonogram and an intravenous pyelogram were ordered which resulted in a misleading diagnosis of polycystic kidney disease. The failure to have a cystoscopy performed constituted gross negligence on the part of respondent Mellon. It was not established that otherwise the conduct of respondents constituted repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient.

(7) During the month of September, 1978, GW was hospitalized at the University of California at Los Angeles. It was determined that she suffered from invasive adenocarcinoma and on September 26, 1978, she underwent a radical cystectomy, urethectomy, vaginectomy, ileostomy, and urinary diversion. The evidence failed to establish that respondents were grossly negligent and/or incompetent in failing to diagnose maligancy in the case of GW; or that their grossly negligent and/or incompetent in delaying said diagnosis of malignancy until August 22, 1978, through repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(8) It was not established by the evidence that the practices of respondents with respect to GW constitute repeated negligent acts and repeated acts of clearly excessive prescribing of drugs and repeated acts of clearly excessive use of treatment and diagnostic facilities as determined by the standard of the local community of licensees; or that, other than respondent Mellon's failure to perform a cystacopy, caused any delay in diagnosing GW's extensive glandular cancer.

IX

FINDINGS RE PATIENT FW

(1) Patient FW, a 29-year-old female, was first seen at the clinic by respondent Freibrun on or about September 10, 1976. Initial diagnoses of bronchitis and low back syndrome were made. FW was treated at the clinic by respondent Solof and respondent Freibrun, or

Physicians Assistants under their supervision, on 28 visits during the period of November 23, 1976 through November 10, 1977.

(2) During at least the period of February, 1977 through October 23, 1977, the date of delivery, FW was pregnant. During this period of time, FW made at least 15 visits to the clinic on which occasions she was treated by respondent Solof and/or respondent Freibrun, or their Physicians Assistants. It was not established that Dr. Solof was grossly negligent and/or incompetent in failing to diagnose and/or make medical record notations as to FW's pregnancy. The patient was obese (5'7-1/2" and about 175 pounds) and had reported having two full term babies previously. During the final weeks of her pregnancy, FW was seen at the clinic chiefly for a bullet wound in her leg and treatment therefor. It is not unreasonable, from the evidence relating to FW, that the patient did not reveal her pregnancy to the respondents or the Physicians Assistants; and that considering her weight and the circumstances of the patient's visits during the last weeks of her pregnancy, that a practitioner might not recognize that she was pregnant.

(3) On or about April 7, and August 8, 1977, FW was prescribed Tetracycline. On or about September 26, 1977, a Terramycin injection was given to FW and Tetracycline was again prescribed to be taken for 14 days. By reason of Finding IX(2), it was not established that respondents Solof and Freibrun were grossly negligent and/or incompetent in prescribing and/or administering and/or allowing to be prescribed and/or administered the above drugs to FW, even though Tetracyclines cross the placenta, are found in fetal tissue and can have toxic effects on a developing fetus which are often related to retardation of skelatal or tooth development; or that respondents' actions in this regard constituted repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(4) Similarly, it was not established that respondents were grossly negligent and/or incompetent in prescribing hydrochorothiazide, Preludin, Actifed, Biphetamine, Fastin, or Dimetapp, for FW at a time when she was pregnant.

X

Findings Re Patient TR

(1) Patient TR, a 52-year-old male was first seen at the clinic on or about February 6, 1978. Treatment was supervised by respondents Solof and Freibrun. The presenting complaints were arthritis and insomnia.

(2) Respondent Solof's supervision of the Physicians Assistants and respondent Freibrun's treatment of TR was inadequate in the following respects:

(a) In taking the patient's past medical history, no current illness was listed. Assessed problems were anxiety neurosis, bronchitis, arthritis and prostatic hypertrophy. However, a chest X-ray taken on February 6, 1978, was interpreted by the radiologist as "severe congestive heart failure, or possible early pulmonary edema. With the degree of cardiomegaly, however, I cannot rule out a pericardial effusion, although this is unlikely." An electrocardiogram was interpreted as ". . . left atrial enlargement; T wave abnormalities and possible interventricle cardiac defect; first degree A-V block." Respondents were grossly negligent in failing to obtain TR's past medical history in the face of the above referenced diagnostic tests which indicated severe heart problems. During the critical period immediately after discovery of the patient's heart condition, the respondents entrusted the treatment and taking of further medical history to their Physician Assistants. There is no indication from the charts that any further medical history was sought; and though a cardiac consult and treadmill testing was noted as being ordered there is no indication of any follow up by either the respondents or their Physicians Assistants during the nine (9) subsequent visits to the clinic by the patient.

Respondent Solof and respondent Friebrun, in taking over the medical management of TR, through their Physicians' Assistants, were grossly negligent in failing to determine that TR had been admitted to West Adams Community Hospital on at least six occasions for severe heart difficulties during the period from 6-30-76 to 1-20-78. There is no evidence that after about February 7, 1978, when the results of the radiological tests were known, that the patient withheld any information from the Physicians Assistants. Rather, the evidence is clear that they made no inquiry and that the respondents failed to follow up and make sure that an adequate patient history was obtained. Respondents were grossly negligent in failing to initiate and follow through an appropriate regimen for TR's demonstrable physical ailments.

(b) During his visits to the clinic, TR was diagnoses as having arthritis, insomnia, chronic obstructive pulmonary disease, abnormal EKG, anxiety neurosis, cough, obesity, prostatic hypertrophy, and chronic bronchitis and was never seen by a physician, except on March 12, 1978, when respondent Freibrun merely refilled the patient's medications.

Respondent Solof's assertion that he was justified in relying on respondent Freibrun's reputation as a cardiologist is unfounded. Solof knew, as did everyone else at the clinic at that time, that Freibrun was aged; extremely ill with cancer; had suffered painful back surgery; that he worked only a few hours per day (and then not every day); was seeing few patients; was not supervising the Physicians Assistants; and was liable to manipulation by the patients.

(c) Further, there was no medical indication for the diagnosis of chronic bronchitis, anxiety neurosis, or chronic obstructive pulmonary disease. In spite of respondent's protestations to the contrary there is no evidence that TR was a chronic tobacco abuser, or had multiple social or economic problems. In prescribing the antidepressants/tranquilizers, the cough syrup containing Codeine, the hypnotics and much

of the Empirin #4, respondents committed acts of clearly excessive prescribing of drugs.

(d) Further in their failure to follow upon on TR's inadequate medical history, and institute a meaningful treatment for his heart problems, respondents, and each of them, committed repeated negligent acts. Solof's assertion that after March of 1978, it was Freibrun's negligence is not borne out by the record. Solof signed his approval of the Physicians Assistants treatment as late as May 19, 1978.

XI

Findings Re Patient MM

Patient MM, a 41-year-old female, was first seen at the clinic on or about May 16, 1978. She was seen on follow-up visits on June 16, 1978, and July 17, 1978. Treatment by Physicians Assistants was supervised by respondents Freibrun and Mellon.

It was not established by the evidence that respondents were grossly negligent and/or incompetent in making the diagnosis that MM was suffering from "acute bronchitis, rhinitis, anxiety neurosis and rule-out tension headaches and sinusitis" in that there were insufficient and/or inadequate tests conducted to substantiate these diagnoses; or that respondents were grossly negligent and/or incompetent for failing to discover that MM was a diabetic receiving Diabenese and also suffering from glaucoma; or that respondents committed acts of clearly excessive prescribing of drugs.

XII

FINDINGS RE PATIENT AB

(1) Patient AB, a 33-year-old female, was treated at the clinic on 18 separate visits between July 26, 1976, and June 14, 1978. Until March, 1977 treatment was rendered by Freibrun, then until August of 1977 by Solof. After August, 1977, treatment was done by the Physicians Assistants supervised by respondents Solof and Freibrun.

It was not established by the evidence that respondents were grossly negligent and/or incompetent in diagnosing AB as epileptic and suffering from migraine headaches on the basis of insufficient tests; or that respondents were grossly negligent and/or incompetent in prescribing Triavil and Cafergot to AB, or that Triavil and Cafergot are contraindicated to anyone who has a diagnosis of epilepsy; or that respondents were grossly negligent and/or incompetent in failing to follow-up on subsequent visits an elevated blood count of 20,000 dated July 28, 1977, and an abnormal T-4 total protein, albumin and albumin globulin ratio dated June 28, 1976; or that respondents were grossly negligent and/or incompetent or committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatments, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient.

XIII

Findings Re Patient JV

Patient JV, a 26-year-old female, was treated at the clinic 28 times between July 29, 1977 and June 28, 1978. She was originally seen by Solof and complained of injuries suffered as the result of an assault. Treatment was for the first six months or so was performed by Solof, and later treatment was supervised by respondents Solof and Freibrun.

(a) Respondents caused blood chemistry testing to be performed on JV on July 29, 1977. It was not established by the evidence that respondents were grossly negligent and/or incompetent in failing to document and/or determine the cause of a serum glutamic oxaloacetic transaminase test result of 155 when the normal range is 0-41; a serum glutamic pyruvic transaminase result of 319 when the normal range is 0-45; a lactic dehydrogenase result of 293 when the normal range is 60-200; and an alkaline phospatase result of 157 when the normal range is 30-115.

(b) It was not established by the evidence that respondents were grossly negligent and/or incompetent in failing to thoroughly investigate JV's medical history of drug addiction in the context of the blood chemistry results referenced

in paragraph (a) above; elevated enzyme test results and the fact that respondents were prescribing for JV tranquilizers, barbiturates, hypnotics, and narcotics on a regular basis. Respondents knew that from the first JV was formerly an addict; but it was not established that they knew that JV had slipped back, and was going through drug detoxification in the Spring of 1978.

XIV

Findings Re Patient LB

(1) Patient LB, a 26-year-old female, was treated at the clinic nine times between January 3, 1978, and December 27, 1978. Treatment was performed entirely by Physicians Assistants supervised by respondent Solof (4 times) and by respondent Freibrun (3 times) and Mellon(twice).

The treatment of LB was inadequate in the following respects:

(a) Respondents, and each of them, committed negligent acts in accepting the Physicians Assistants' diagnoses of insomnia, bronchitis, anemia, and migraine headaches on the basis of insufficient justification therefor.

No blood or neurological tests were ever given; and the patient was variously assessed as having insomnia, migraine headaches, bronchitis, rhinitis, chronic obstructive pulmonary disease, acute lumbo-sacral strain. The patient never saw a physician and was prescribed scheduled drugs and/or narcotics for each of the diagnoses, in spite of what amounts to essentially normal physical observations and an inadequate medical history.

(b) Respondents, and each of them, committed repeated negligent acts and acts of clearly excessive prescribing; there being no medical indication for the prescribing of Tuinal, Valium, Placidyl, and on most of the visits Empirin #4 and Robitussin, A/C.

(c) It was not established by the evidence that respondents were grossly negligent in allowing the prescribing of said drugs to LB by reason of her recent history of drug abuse. It was not established that they knew or should have known said facts.

Findings Re Patient AJ

Patient AJ, a 41-year-old female, was treated at the clinic eight times between May 24, 1978, and February 7, 1979. Treatment was performed entirely by the Physicians Assistants, with Freibrun supervising on May 24, Solof supervising on June 27, and October 24, 1978 and Mellon supervising the rest of the time.

(a) It was not established by the evidence that respondents were grossly negligent and/or incompetent in failing to pursue possible problems presented by elevated alkaline phosphatase and lactic dehydrogenase test results obtained in May, 1978.

(b) Respondents, and each of them, repeatedly accepted the Physicians Assistants assessment of "low back syndrome," but never evaluated the same or caused it to be evaluated, or implemented any treatment modulity for the condition; except authorizing the ordering of pain killing drugs. Said conduct constituted repeated acts of clearly excessive prescribing and repeated negligent acts. Additionally, there was also no sufficient medical indication for the prescribing of Tuinal and Placidyl and no justification for the diagnosis of anxiety neurosis or for prescribing Mellaril therefor.

XVI

Findings Re Patient FR

(1) Patient FR, a 25-year-old female, was treated at the clinic at least seven times between May 31, 1978 and January 19, 1979. Treatment was performed entirely by Physicians Assistants supervised by respondents Solof (on October 17, 1978 and January 19, 1979) Freibrun (on May 31, 1978) and Mellon the rest of the time.

(2) Respondents' treatment of FR was inadequate in the following respects:

(a) Respondent Mellon was grossly negligent in failing to thoroughly investigate or cause the investigation of patient FR's constant complaints of menstrual cramps to rule out a pathology with respect thereto.

(b) Respondents, and each of them, committed a negligent act by their failure to investigate the patient's history of drug abuse. Freibrun by his failure to investigate, or cause the investigation, of the notation on the initial interview that the patient claims a problem sleeping; Solof and Mellon because they knew about the history of drug abuse and were aware that FR was being drug checked by the Los Angeles Probation Department, and made no follow-up inquiry. As to Mellon it constitutes repeated negligent acts; as to Freibrun and Solof it constitutes an act of ordinary negligence only.

XVII

Findings Re Patient DC

(1) Pateint DC, a 29-year-old female, was treated at the clinic four times between April 10, 1978, and October 17, 1978. All examination and treatment was performed by Physicians Assistants supervised by respondents Solof (on April 10th) Freibrun (on May and June 10) and Mellon (on September 16).

It was not established by the evidence that respondent Solof was grossly negligent and/or incompetent in failing to take a complete medical history of DC and failing to document completely an adequate physical examination of DC. Solof did commit an act of ordinary negligence in not requiring his Physicians Assistant to take a complete medical history of DC on the first visit.

(2) There was no medical indication for the prescription of Tuinal on the patient's initial visit and respondent Solof is responsible for allowing the prescription of a scheduled drug without such indication.

(3) There was no medical indication justifying the prescription of Triavil (by Freibrun) or Carbitral (by Mellon) and those respondents are responsible for such prescriptions being issued without indication.

XVIII

Findings Re Patient BH

(1) Patient BH, a 26-year-old female, was treated at the clinic 21 times between December 2, 1977, and November 10, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(a) It was not established by the evidence that respondents were grossly negligent and/or incompetent in prescribing narcotic and hypnotic drugs for BH at a time when she was assessed as having post-concussion syndrome as a result of head concussion in that narcotic drugs, such as codeine in Empirin #4, and hypnotics (Tuinal was ordered on the first visit) are contrindicated in the case of a possible internal head injury. The hypnotic, Tuinal, was prescribed prior to the visit in which the patient was assessed as having post-concussion syndrome.

(b) Respondents, and each of them, were grossly negligent in their supervision of the Physicians Assistants treatment of BH in that although BH continued to complain of headaches, complained of seizures and was diagnosed as having a post-concussion syndrome and seizure disorder on separate occasions, respondent Solof and Freibrun failed to have conducted any neurological examination, evaluation and/or consultation. No electroencephalogram or other diagnostic tests for seizure disorders were ever performed.

While the chart for March 30, 1978, indicates that the patient related a seizure, there is no indication that an adequate history or description was elicited. The Physicians Assistant noted "neurologic consult", however, it is apparent that no such appointment was made, and that neither respondent Solof or Freibrun followed up to assure that the appointment was made or that proper steps were taken on subsequent visits, all of which were allowed to be handled by Physicians Assistants. Ultimately on July 27, 1978, an appointment for a neurological consult was apparently made (at least the date of 8/3/78 is noted in the chart). However, that appointment was apparently not kept and respondent Mellon did nothing further to assure adequate diagnoses or treatment as late as November, 1978.

(c) It was not established by the evidence that respondents were grossly negligent and/or incompetent in failing to monitory and/or discuss a six-day hospitalization of BH at Monte Sano Hospital in January of 1978 and in failing to timely diagnose the perceived pneumonia which resulted in said hospitalization. Respondents

were in fact the ones who succeeded in hospitalizing BH, at Monte Sano Hospital, after she had been denied admission at another hospital.

(d) While Phenobarbital and Dilantin are medically indicated for seizure disorder, the prescriptions therefore, made by the Physicians Assistants and approved by the respondents, were not based on good faith prior examinations.

(e) Except as set forth in paragraphs (b) and (d) above, the evidence failed to establish that the respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient.

XIX

Findings Re Patient VB

(1) Patient VB, a 49-year-old female was treated at the clinic four times between March 10, 1978, and May 19, 1978. Treatment was performed by Physicians Assistants supervised by respondents Solof and Freibrun.

(a) Respondent Freibrun was negligent (but not grossly so) in failing to require the Physicians Assistants to obtain a complete medical history of VB. It was not established that respondent's failure to investigate the significance of laboratory tests which indicated elevated calcium, phosphorus, alkaline phosphatase, and triglycerides constituted gross negligence. The laboratory values were only minimally elevated, and respondents re-testing later in the year was sufficient.

(b) It was not established that respondents were grossly negligent and/or incompetent in failing to obtain a complete medical history for an assessment of uncontrolled hypertension. In the patient's second visit the blood pressure was normal. When uncontrolled hypertension was diagnosed, the patient was treated with a diuretic and given diet advise. It was not established that Actifed, a drug which was marginally indicated, was actually contraindicated in cases of hypertension.

(c) There was no medical indication for the prescription of Placidyl by the Physicians Assistant (under the supervision of Freibrun) on March 24, 1978; and no medical indication for the prescription of Tuinal by the Physicians Assistant (under the supervision of Solof) on April 13, 1978. Further, there was never a justification by adequate history, description, examination, or observation to justify the diagnosis of anxiety neurosis for the patient VB; despite the assertion by respondents that all or most "ghetto practice" patients have it.

(d) Except as set forth in paragraph (c) above, it was not established that respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient.

XX

Findings Re Patient EM

(1) Patient EM, a 55-year-old male, was treated at the clinic 17 times between March 31, 1978, and February 6, 1979. All treatment to EM was rendered by the Physicians Assistants. Their supervision was under respondents Solof (March 31, June 26, September 6, Ocotber 4, October 25, and December 26, 1978, and on January 9, 1979. Freibrun and Mellon (on 7 visits); and apparently without supervision on April 28, 1978.

(2) Respondents' treatment of EM was inadequate in the following respects:

(a) Respondents, and each of them, were grossly negligent in failing to initiate and carry out an appropriate treatment regiment and medication program for uncontrolled hypertension; and for failing to adequately document or require the documentation of what treatment was rendered to EM by their Physician Assistants.

While the April 28, 1978, chart noted that the Physicians Assistant planned to increase blood pressure medicine as indicated there is no record of what, if any, medicine he was referring to or how or

in what manner it was expected to deal with the assessments made for EM. A blood pressure medication was first documented on EM's chart on his twelfth (12th) visit to the clinic on October 25, 1978, and his blood pressure at that time was 160/100. The only other indication of a treatment regiment for EM's hypertension was a Physicians Assistants note on November 12, 1978, indicating reduce salt and reduce pork which was repeated by the same Physicians Assistant on January 9, 1979.

(b) Respondent, and each of them, were grossly negligent in failing to investigate and treat repeated complaints by EM of severe headaches. The Physicians Assistants, and the physicians supervising them, other than writing "tension headache" on the chart never attempted to identify and document the type of headache, the area of pain, the length, the severity, when they occurred, or their relation to other patient problems. The only treatment offered EM was 17 consecutive prescriptions for Empirin #4 along with antidepressants or tranquilizers on at least a dozen of those visits.

(c) In addition to the above scheduled drugs, EM was prescribed Tuinal or other hypnotic sleeping medication on at least five (5) of the seventeen visits and never carried an assessment or diagnosis of insomnia. Said drugs were prescribed by respondents without medical indication or good faith prior examination therefor.

(d) Except as set forth above, the evidence failed to establish that respondents were grossly negligent and/on incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient,

Findings Re Patient BJ

(1) Patient BJ, a 39-year-old male, was treated at the clinic 11 times between August 29, 1977, and June 5, 1978. Treatment was supervised by respondents Solof and Freibrun.

(2) In the patient's initial visit, his presenting complaints were shoulder pain for ten years (which the patient attributed to arthritis) and insomnia for three months.

BJ said he smoked 1/2 pack of cigarettes a day and took Empirin #4 and Tuinal. Respondent Solof diagnosed bilateral shoulder pain of unknown etiology, chronic obstructive pulmonary disease, and anxiety neurosis; he prescribed Empirin #4 and Tuinal, and had shoulder X-rays taken among other tests. No notation was made, nor apparently any effort expended to determine who had been prescribing the prior Empirin #4 and Tuinal for the patient.

The shoulder X-rays were normal, and after the initial visit (for almost a year) the patient carried diagnoses of shoulder pain, anxiety neurosis, insomnia, and various respiratory problems.

There was no medical indication for the diagnosis of anxiety neurosis, and nothing was done to identify or treat it. After the initial visit, no attempt was made by the respondents, or their Physicians Assistants, to clarify the unknown etiology of BJ's shoulder pain; no arthritis work-up was ever performed; on the few occasions when the extremities were checked, range of motion was good; other observations were grossly normal. No investigation was ever made or documented to identify the causes of his insomnia.

It is apparent that after the initial visit, the patient merely came to the clinic to have his prescriptions for Empirin #4 and Tuinal refilled, and no good faith prior examinations were performed to justify the continued prescribing of those scheduled drugs.

XXII

Findings Re Patient CE

(1) Patient CE, a 34-year-old female, was treated at the clinic 11 times between March 9, 1978, and October 2, 1978. All treatment afforded CE was by Physicians Assistants. Said treatment was supervised by respondents Solof (March 9, April 19, May 4, and October 2) and Mellon (July 11, August 4, and September 9).

(a) It was not established by the evidence that respondents were grossly negligent and/or incompetent during the course of their treating CE on her first six visits for various complaints in failing to determine that CE was pregnant. On her initial visit, the patient reported her last menstrual period as being February 1, 1978, and no irregulaties of her cycle were noted. At the time

of her first visit, she was about a week overdue. On her next visit she was given a pelvic examination by the Physicians Assistant. Though the patient may not have volunteered the information as to her cycle on that visit or succeeding visits, it is obvious that she was never again asked questions about her last menstrual period. There is no evidence that CE was actively concealing any information.

Respondents Solof and Friebrun were negligent in their supervision of their Physicians Assistants, in light of the patient record, in that neither of them required the Physician Assistants to inquire and note the patient's last menstrual periodon the chart or made any inquiry themselves. Their omission is, however, found to be ordinary and not gross negligence.

The clinic first learned of her condition on May 30, 1978 when she reported she had had an abortion.

(b) In light of the above finding it cannot be said that respondents were grossly negligent and/or incompetent in prescribing potentially teratogenic and embryotixic drugs to CE at a time when she was pregnant.

(c) It was not established by the evidence that respondents were grossly negligent and/or incompetent in prescribing penicillin and/or ampicillin (closely related to penicillin) for CE at a time when they knew or reasonably should have known that CE was allergic to Penicillin. While in her patient history CE reported an allergy to Penicillin. She also reported, on the same visit, that she was taking ampicillin.

(d) Respondent Solof committed an act of ordinary negligence in his approval on October 2, 1978, of his Physicians Assistants failure to document and investigate a history of seizure disorder by CE. No effort was made to get in touch with USC Medical Center, or CE's doctor, in an attempt to coordinate the treatment of the patient. Respondent approved a "re-fill" of Phenobarbital and Dilantin, without any information other than that the patient wanted them.

(e) In her 11 visits to the clinic over a period of only 8 months, CE had an abortion and carried diagnoses of bronchial asthma, tension-headaches, chronic pelvic inflammatory disease,

anxiety neurosis, bronchitis, chronic obstructive pulmonary disease, acute bronchitis, dental abcess, urinary tract infection, acute left knee pain, chronic lumbo-sacral strain, migraine headaches, anemia, osteoma, seizure disorder, mild depression, and vaginitis; and CE was never seen by a doctor.

As to her back and knee pain, no adequate history was ever taken. Her spine and knee X-rays were normal studies; no neurological examination was ever given or ordered; no investigation was undertaken to identify the nature of the pain, the length, frequency, or times; and similarly no adequate work-up was done to identify and treat her headache pains or her insomnia, or her anxiety neurosis.

Respondents never instituted or ordered the institution of any accepted modality of treatment of CE for her back pain, headache pain, insomnia or anxiety, other than nine or ten prescriptions each of Empirin #4, hypnotics, and tranquilizers, all scheduled drugs.

As to CE, respondents, and each of them, prescribed said drugs without an adequate good faith prior examination and said conduct also constituted repeated acts of clearly excessive prescribing.

XXIII

Findings Re Patient MW

(1) Patient MW, a 36-year-old female, was treated at the clinic eight times between November 18, 1977, and July 20, 1978. Treatment was supervised by respondents Solof, Freibrun and Mellon.

(2) It was not established by the evidence that respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient.

Patient MW's presenting complaints on her initial visit were pain in her lower leg and upper thigh, and a chest cold. Unlike the treatment rendered CE, MW's pain was located and described, an X-ray of her lumbo-sacral spine showed some narrowing of the disc space at L4-5 and a slight tilt to the right.

Pain was determined worse at bed time, allowing a reasonable inference that it interfered with sleep, and she was first tried on Benadryl before being prescribed any stronghypnotic sleep medication. On her third visit she was personally examined by respondent Solof; was prescribed back exercise; and was recommended for physical therapy. She had a positive drug screen for "morphine, Codeine" on her second visit; however, it was equally reasonable to attribute this to her taking the Empirin #4 (prescribed on her first visit) as opposed to an indication of patient drug abuse.

XXIV

Findings Re Patient JCI

(1) Patient JCI, a 34-year-old female was treated at the clinic 12 times between August 29, 1977, and May 25, 1978. All treatment rendered to JCL was performed by Physicians Assistants. The supervision was done by respondentSolof on all visits except February 21, March 2, March 23, and May 25, 1978, which were done by Freibrun.

(2) On her initial visit, the patient's presenting complaints were numbness in the 4th finger of the left hand for two months, and increased urination with pain (which the patient described as "kidney trouble") for two weeks. The examining Physicians Assistant also elicited a complaint of lumbo-sacral pain, and made a diagnosis of urinary tract infection and anemia. At some later time, respondent Solof gratuitously added to the chart diagnoses of menopause and chronic obstructive pulmonary disease, apparently after noting in the history reported by the patient that she had a hysterectomy five years prior (at age 29) and that she smoked two packs of cigarettes a day.

The patient was prescribed B-complex vitamins, iron, and Azo Gantrisin and told to return in two weeks. No controlled substances were prescribed.

(3) The patient did not return for two months. On her next visit, JCI complained of pain in her back radiating to her stomach for one day, and constant constipation. The Physicians Assistant diagnosed gastroenteritis and constipation and included all of the prior diagnoses from the August, 1977, visit though it is obvious that he did not examine her or run further tests to determine if she was anemic, still had the urinary infection, had any menopausal problems, or smoker's cough. The Physicians Assistant prescribed colace, a fleet enema and Tuinal. Respondent Solof signed his

approval on the chart at a later time.

There was no medical indication for the prescription of Tuinal, and no prior good faith medical examination was conducted relating thereto.

(4) On her third visit (January 18, 1978) JCI came to the clinic complaining of a "boil" under her arm. She was described by another Physicians Assistant, who saw her to treat the abscess under her right arm, as a "34 year old Black female with a history of insomnia and migraine headaches and occasional constipation." None of this "history" was investigated, and after a systems check which was totally unremarkable, except for the abscess under her right arm, JCI was diagnosed as having insomnia, constipation, migraine headaches, abscess, and flu syndrome. She was prescribed, more Tuinal, Empirin #4, Mylanta, low calorie diet, Tetracycaline, valium and citrate of magnesia. Her abscess was drained and packed, a culture ordered, and she was told to return the next day.

There was no prior good faith medical examination relating to the prescriptions of Tuinal, Empirin #4, or Valium; and no medical indication for the prescribing of said controlled substances to JCI.

(5) The patient returned three days later to have her abscess checked, and the Physicians Assistant assessed that the abscess was in a good stage of healing. He then prescribed 30 capsules of Fiorinal with Codeine #3. There was no medical indication for the prescription of said controlled substance.

(6) During her 12 visits to the clinic JCI was diagnosed by Physicians Assistants to have urinary tract infection, anemia, gastroenteritis, constipation, chronic obstructive pulmonary disease, vaginitis, migraine headache, insomnia, flu syndrome, abscess, anxiety neurosis, bronchitis, rhinitis, general weakness, skull contusion, rib contusion, left knee abrasion, tension heasache, and costocondritis. JCI was never seen by either Solof or Freibrun.

Until JCI suffered a fall on March 25, 1978, no adequate good faith prior examination was conducted relating to the patient's complaint of headache pain, nor was any investigation done relating to her complaint (after January 18, 1978) of insomnia, or anxiety neurosis; yet controlled substances Empirin #4, Tuinal, and Valium were consistently prescribed for her on her visits.

(7) It was not established that respondents were grossly negligent and/or incompetent in ordering ampicillin for JCI even though it was known that she gave a history of allergy to the closely related drug, penicillin. The wound culture study of her abscess was resistant to Tetracycline she had been taking, but was sensitive to ampicillin; and respondent's choice to try an oral penicillin derivative for 10 days was not outrageous.

XXV

Findings Re Patient JC2

(1) Patient JC2, a 52-year-old female was treated at the clinic 35 times between August 16, 1977, and August 9, 1978. Treatment was rendered by Physicians Assistants on 30 of the 35 visits (22 of those visits from August 16, 1977, through June 26, 1978, were supervised by Solof) , (6 visits from February 24, 1978 through June 15, 1978, were supervised by Freibrun), (3visits from July 7, 1978 through August 9, 1978, were supervised by Mellon). Solof personally saw the patient on October 31, November 21, and December 12, 1977 and on January 4 and March 23, 1978.

(2) The patient first visited the clinic on August 16, 1977, with a presenting complaint of "weight control." She was seen by a Physicians Assistant who diagnosed "obesity" and ASCVD." The Physicians Assistant ordered a urinalysis, chest X-ray, CBC and Panel, and an EKG. He noted "return in 2 weeks" and "refer to weight clinic." There is no evidence that the referral was ever made, and if made was ever kept. He also prescribed 30 Tuinal. There was no medical indication or good faith prior examination for the prescription of Tuinal.

Respondent Solof, at a later time, signed the chart and gratuitously added a diagnosis of "anxiety"; in an obvious attempt to justify the prior Tuinal prescription.

(3) It was not established by the evidence that respondents were grossly negligent and/or incompetent in failing to adequately evaluate and treate a diagnosis of hyperkalemia, a serious electrolyte imbalance, which leads to weakness and gastrointestinal symptoms and which can lead to cardiac arrest.

The patient's blood work results dated November 1, 1978, did shown an electrolyte imbalance; however, the report contained a note that the results might be invalid due to prolonged serum/RBC contact. A diagnosis of hyperkalemia was noted on the patient's chart for her

November 4, 1977, visit; and on November 14, 1977, the "lytes" were repeated, and the report of the blood test showed electrolytes within normal range.

(4) From about November, 1977 on, the patient presented complaints of "arthritis" and in December, 1977 complained of "back and leg pain." Respondents at no time took a complete history of the severity, length, area, time, or frequency of JC2's pain. She received no neurological examination or referral. In two charts "flexion 70°" is noted without any showing of the part of the body or extremity or joint flexed, and no indication if it was forward, backward or laterally. Most observations were grossly normal and no arthritis work-up was ever done.

No physio therapy, or exercise was ever attempted. In short no treatment pattern responsive to back or leg pain was ever initiated. Assuming that the continuous prescribing of Empirin #4 was given for the patient's complaints of "pain", no good faith prior examination was ever given to justify said prescriptions.

(5) As to the complaint and diagnosis of insomnia, no specific history or work-up was ever done. No meaningful questioning of JC2 was ever recorded and the first prescriptions for Tuinal had absolutely no medical indication. As to the latter sleeping pills prescribed, no adequate good faith prior examination was conductes.

(6) Not only were the patient's pain history and physical work-ups insufficient, but for a year this patient was prescribed a minimum of three (3) grains of Empirim Codeine per day. During the month of January, 1978, she was receiving five (5) grains a day. The patient was visiting the clinic virtually weekly from November, 1977 through June of 1978 for "med refill" or "arthritis meds" with little or no examination referrable to her "pain" problems. The patient received 150 Empirim with Codeine #4 in one month and averaged 100 per month for six months. During that same time she got 3 grains of Tuinal a day, plus 60 Doriden, 30 Placydil, and 30 Valium. During the same time she was given two (2) intramuscular Valium shots and two (2) intramuscular Talwin injections.

The conduct of respondent, and each of them, constitutes repeated acts of clearly excessiving prescribing and administering drugs to the patient JC2.

(7) Other than set forth above, it was not established that respondents were grossly negligent and/or incompetent in administering Talwin to JC2 at a time when JC2 had been diagnosed as suffering chronic bronchitis and asthma in that Talwin may cause respiratory depression and should be used with caution in patients with bronchial asthma.

The diagnosis of the patient at the time of the first shot was obesity, hyperkalemia, and viral syndrome; and at the time of the second visit a chest cold assessed as chronic bronchitis.

XXVI

Findings Re Patient JG

(1) Patient JG, a 38-year-old male, was treated at the clinic 10 times between December 21, 1977, and September 28, 1978. The patient was seen by respondent Solof on his initial visit and on April 21, 1978. On all other visits the patient was seen by Physicians Assistant Leonard Washington, whose treatment was supervised by respondents Solof (on January 21, and on February 21, 1978) Freibrun (on March 21, May 20, and June 20, 1978) and Mellon (on July 20 and September 28, 1978). Patient's August 25, 1978 visit was apparently unsupervised.

(2) On his initial visit JG's presenting complaints were "back pain" and "insomnia". He said he had a "back injury" five (5) years prior; he had no history ofillness, surgery, allergy or medication; drank alcohol occasionally and smoked 3/4 of a pack of cigarettes a day.

He was given a chest X-ray, lumbosacral spine X-ray, an EKG, a urinalysis, and blood panel. He was diagnosed as having "acute/chronic lumbosacral sprain", "chronic obstructive pulmonary disease", insomnia", and "obesity"; and was prescribed 30 Empirin #4, 30 Tuinal gr.3, Robitussin A/C, "back exercise", and told to reduce cigarettes.

(3) It was not establishes by the evidence that respondents were grossly negligent and/or incompetent in failing to explore possible causes of laboratory studies indicating elevatws alkaline phosphatases, serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, and triglycerides even though such elevated chemistries can represent such serious conditions as, but not limited to, myocardial infarction, skeletal muscle disease or liver disease.

Though JG's initial blood test values from December 21, 1977 were elevated as set forth above, the elevations (except for Triglycerides) were not extreme. His EKG was normal and there was no indication of skeletal muscle disease. On February 21, 1978, a diagnosis of hyperlipidemia was made, on April 21, 1978 he was given diet information, and his May 20,1978, blood test repeat showed normal triglycerides. While respondents may have been slow to react to the first blood test, their omission did not constitute gross negligence.

(4) As to JG's complaint of back pain, respondents never adequately investigated, identified, or examined the patient in response to said complaint. His lumbra-sacral X-ray was perfectly normal; no neurological examination or referral was ever done and no adequate history was ever taken; aside from notations of "flexion 70°", "back exercise", and "firm mattress" no treatment regiment responsive to the patient complaints was ever instituted other than a monthly prescription of Empirin #4 to a patient without a history of taking medication. In the ten (10) or so months that the patient visited the clinic, the only information obvious from the records is that the medications did not help and were not being monitored. On nine (9) of his (10) visits, JG's back was not even examined.

The above conduct constitutes repeated acts of clearly excessive prescribing; and the prescribing of controlled substances without an adequate good faith prior examination.

(5) Similarly with respect to JG's complaint of "insomnia", and the Physicians Assistant's diagnoses of "anxiety neurosis" of January 21, 1978, no adequate history was ever taken, no work-up was ever done, nothing meaningful was done to investigate or identify the causes, times, or type of problems the patient was having. The ten (10) monthly prescriptions of Tuinal, Placydil or Noludar made or approved by the respondents constitutes the prescribing of controlled substances without an adequate good faith prior examination; and repeated acts of excessive prescribing of drugs.

XXVII

Findings Re Patient BA

(1) Patient BA, a 29-year-old male, was treated at the clinic 25 times between February 17, 1978, and January 23, 1979. On all of BA's visits to the clinic

he was seen only by the Physicians Assistants, except on November 21, 1978, when he was seen but obviously not examined by respondent Mellon. The Physicians Assistants' supervision was attributable to respondent Freibrun (8 visits between February 17 and June 22, 1978), (Mellon (7 visits between July 18, and November 30, 1978), and Solof (6 visits between October 27, 1978, and January 23, 1979). The patient visits on October 3, October 13, and December 14, 1978, were apparently unsupervised.

(2) On his initial visit BA's presenting complaints were "can't sleep" and "pain in back". He said he was lifting weights in 1977 and injured his back; gave a history of no illness, no surgery, no allergies, no medication, and no cigarette smoking.

The Physicians Assistant observed all systems to be normal; ordered a blood panel, chest and lumbar spine X-rays, and an EKG; and diagnosed "low back syndrome" and "anxiety neurosis". He prescribed 30 Empirin #4, 30 Tuinal gr. 3, and told the patient to return in two (2) weeks.

The patient returned in 10 days with presenting complaints again of "insomnia" and back pain". BA's lumbar spine X-ray (3 views) had been perfectly normal. No back examination was performed. Observation of his eyes, lungs and heart were all normal. His blood test taken on February 17, 1978, showed an elevates triglyceride and total CPK.

He was diagnosed as having bronchitis, chronic obstructive pulmonary disease, low back syndrome, anxiety neurosis, and hyperlipidemia. There was no justification by history or examination for the diagnosis of chronic obstructive pulmonary disease, bronchitis, or anxiety neurosis. There was no adequate examination for the diagnosis of low back syndrome.

BA was prescribed 30 more Empirim #4, and told to go on a low fat diet.

(3) As to BA's complaint of back pain, no adequate medical history was ever taken, the nature, severity, length, location, and time of the pain was never determined; no neurological examination or referral was ever made; the degree of incapacitation was never determined; and no treatment modality was ever instituted reasonably calculated to respond to BA's complaint of a back problem.

The conduct of respondents, and each of them, set forth in paragraph (2) above and this paragraph

constitutes the prescribing of controlled substances without a good faith prior examination; and also constitutes repeated acts of clearly excessive prescribing of drugs.

(4) Similarly with respect to BA's complaint of "insomnia" and the Physicians Assistants diagnosis of "anxiety neurosis", no adequate history was taken, no specific work-up was ever performed, nothing was done to determine anything referable to the patient's complaint or support the Physicains Assistants diagnosis.

The continual prescription of Tuinal, Placydil and Doriden between February 17, 1978 and November 21, 1978 by respondents Freibrun and Mellon constitute repeated acts of clearly excessive prescribing of drugs, as well as the prescribing of controlled substances without a good faith prior examination.

(5) In most of BA's visits between February and September, 1978, and in December, 1978 and January, 1979, when Robitussin A/C was prescribed there was no sufficient medical indication for the prescription and in instances in the Fall of 1978, when a "slight cold" or "cough" was complained of no meaningful examination took place to justify the prescription.

Said conduct constitutes repeated acts of excessive prescribing on the part of each and all of the respondents, as well as the prescribing of controlled substances without a medical indication or prior good faith examination therefor.

XXVIII

Respondent Solof began as an employee at Victoria Medical Group in May of 1977. Freibrun was already employed there. In August of 1977, Hunter Vassar began working at the clinic under an "extended preceptorship" as a Physicians Assistant with Solof as his supervisor. A few months later Leonard Washington was employed as a Physicians Assistant with Solof and Freibrun as his supervisors. Initially, Solof worked at the clinic about seven hours a day and saw patients. After Vassar was hired Solaf worked about 3 or 4 hours a day and saw fewer patients, spending about 2 hours a day going over charts. After Washington was hired he worked fewer hours, saw fewer patients and went over many more charts in the same number of hours. Freibruen by early 1978 was only working an hour or two a day and missed many days of work. It was well known in the clinic that he had cancer, suffered pain from that and from back surgery, was aged and infirm, and that patients took advantage of him. In 1978 and 1979 he rarely saw patients.

Respondent Mellon was employed at Victoria from July, 1978, to March of 1979, except for rare occasions he never saw a patient. He worked a few hours a day reviewing charts. Respondent Solof returned to the clinic in the autumn of 1978, and became the legal owner on January 1, 1979.

The clinic was open six(6) days a week for about ten (10) hours a day. Commencing in the autumn of 1977 virtually all patients were seen by the Physicians Assistants, and practically all diagnosis and treatment was rendered by them.

The Physicians Assistants worked a 5 day 40 hour week, alternating Saturdays. Each of them saw about 40 patients per day. For over half the hours that the clinic was open for business, there would be no doctor present. When they were there, the doctors spent most of their time scanning and signing the charts of the patients seen by the Physicians Assistants on prior days.

The clinic had a direct telephone tie line to the West Adams Pharmacy, across the street. The pharmacy had been provided with pre-printed, already filled in, prescription pads for the physicians, and virtually all prescriptions were phoned in by the Physicians Assistants.

There was no adequate check on the prescription practices of the Physicians Assistants, and no direct supervision of their work from late 1977 through 1979. During that period, Vassar and Washington functioned autonomously and practiced medicine without being licensed to do so. Respondent, and each of them aided and abetted these unlicensed men to practice systems and modes of treating the sick or afflicted. There is no question that the respondents, and each of them, were helping the Physicians Assistants to practice medicine, rather than the Physicians Assistants helping the doctors.

XXIX

By January of 1979 the autonomy of the Physicians Assistants at Victoria was such that:

A. On or about January 11, 1979, Leonard Washington, Physician's Assistant prescribed for Marlicia Voisard (a Board undercover agent) aka T[redacted] J[redacted] the controlled substances Placidyl and Tylenol with Codeine.

B. On or about December 13, 1978, Hunter Vassar, Physician's Assistant, prescribed for Voisard the controlled substance Amytal.

C. On or about February 5, 1979, Vassar, using the name of "Dr. Mellon," prescribed for Voisard the controlled substances Carbrital, and Tylenol with Codeine.

The above prescriptions, and each of them, were made without medical indication therefor, and without an adequate good faith prior examination.

Respondent Solof aided and abetted the unlicensed practice of medicine by employing Washington and Vassar, not supervising them, and allowing them to prescribe the drugs Placidyl and Tylenol with Codeine, Amytal and Carbrital which said prescription practice constituted the unlicensed practice of medicine.

XXX

In excess of 90% of the patients at Victoria Medical Group were recipients of the California Medical Assistance Program, and all of the patients in Findings VIII through XXVII were on Medi-Cal. Respondents, and each of them knew, or should have known, that as to said patients, the Physicians Assistants under respondents' supervision were not performing adequate comprehensive examinations of said patients, and in many cases inadequate intermediate examinations; and knew that they were signing for and billing Medi-Cal for service not rendered to said patient.

The above conduct constitutes dishonesty and deceit on the part of respondents, and each of them.

XXXI

Findings Re Respondent Mellon Only

A. On or about the following dates, respondent Mellow wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of G[redacted] W[redacted]: 11/3/78 (#4686M30); 12/2/78 (#4686M42); 12/5/78 (#4686M44); 2/5/79 (#4686M56); 2/7/79 (#4686M59); 2/16/79 (#4686M62); 2/17/79 (#4686M63); 3/1/79 (#4686M68); 3/16/79 (#4686M75); and 3/27/79 (#4686M83).

B. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Preludin for an individual by the name of W[redacted] J[redacted]: 11/7/78 (#176954); 11/22/78 (#325629); 11/27/78 (#553858); 11/28/78 (#325780) 1/3/79 (#262437); 1/3/79 (#555009); 2/2/79 (#555810); 2/2/79 (#151381); 2/3/79 (#556441); 3/1/79 (#385093); 3/23/79 (#180434); 4/2/79 (#180756); 4/12/79 (#264877); 4/13/79 (#557874); 5/16/79 (#157376); 5/23/79 (#265893); 6/5/79 (#302617); 6/6/79 (#158319); 6/11/79 (#560505); 6/21/79 (#266618); 6/26/79 (#288028); 7/12/79 (#160343); 7/15/79 (#263869); and 8/21/79 (#306500).

C. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of I[redacted] G[redacted]: 11/8/78 (#4686M33); 12/4/78 (#4686M43); 1/4/79 (#4686M51); 1/5/79 (#4686M53); 2/2/79 (#4686M58); 2/23/79 (#4686M65); 3/23/79 (#4686M80); 4/15/79

(#4686M74); 4/10/79 (#4686M10); 4/24/79 (#4686M18); and 7/15/79 (#4308G55).

D. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of H[redacted] S[redacted]: 3/13/79 (#4686M73); 4/2/79 (#4686M86); 12/9/78 (#4686M46); 2/21/79 (#4686M64); and 4/20/79 (#4686M20).

E. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of D[redacted] M[redacted]: 11/24/78 (#4686M37); and 3/30/79 (#4686M12).

F. On or about the following date, respondent Mellon wrote a prescription for the narcotic, dangerous drug Dilaudid for an individual by the name of J[redacted] J[redacted]: 12/12/78 (#4686M47).

G. In truth and in fact, the above said prescriptions were written by respondent Mellon without a good faith prior examination and medical indication therefor in that the said prescriptions were neither intended for nor provided to the individuals in question but were used by respondent Mellon to divert the drugs in question to respondent Mellon's own illegal use.

XXXII

Findings Re Certain Witnesses

After viewing, hearing and considering the credentials, experience and evidence of certain witnesses the following findings are made:

A. The testimony of the expert witness Dr. Stefan Orr is found to lack credibility. Dr. Orr has little or no experience in, or knowledge of, the standards of practice in the medical community for the period in question herein; and by reason of his relations with the clinics of respondent Solof, his animosity toward the California Medical Assistance Program, and paragraph B, below, his opinion testimony was rejected.

B. While Dr. Richard Hymon's knowledge and credentials are not in question, and his testimony and opinions regarding particular practices, diseases, treatment and protocols referable to particular entries in the charts and documents admitted into evidence was helpful and credible; his opinion testimony relative to the good faith examinations, certain medical indications, and the validity of prescription practices at issue in this matter were largely based on, or tainted by, facts not admitted in evidence herein, and were rejected. Similarly the opinion evidence of Dr. Orr as to said matters was rejected.

C. Respondent Solof's testimony as to his lack of knowledge of what was occurring at the clinic during the period covered by the Accusation is not believed. While it is probably true that Solof as a young doctor working 7 hours a day in the clinic in mid-1977 was naive and uninformed and not aware of the drug problems in the neighborhood and at the clinic; and while at first, in August, 1977, or shortly thereafter, he worked fairly closely with his Physicians Assistant and performed some supervision; it is equally true that by 1978 that naivety was rapidly disappearing; respondent's protestations to the contrary not withstanding. He knew that Freibrun was ill and not working or supervising; he knew that he himself was only signing charts most of the time; he was suing the prior clinic owner for damages which would end up with him as the owner; and he knew that the Physicians Assistants were working autonomously. His asserting that he was "barred" from the clinic by a court judgment from May, 1978, to January, 1979 was not established by the evidence. He was at the clinic (or at least signing charts) as late as June 26, 1978 and as early as September 2, 1978; he admits to returning to the clinic in the fall of 1978 to "protect his interests", and took over as complete legal owner by January 1, 1979. He was aware that Mellon was not seeing patients, was not coming to work, and was merely signing files. Solof's asserted naivety and lack of knowlege in January of 1979 is not unlike the proverbial piano player in the bordello who claims that he does not know what is going on upstairs.

D. The evidence of Sam Kapelson, retired (1958 to 1980) agent with the Department of Justice, Bureau of Narcotics Enforcement, that codeine was not a commonly abused drug in the period August, 1977, to March, 1979, is not persuasive. While in his job as Supervising Agent during those years, Desoxyn, Tuinal, Seconal, Quaalude and Ritalin may have been his top priority (Vaoissard first requested Quaalude from the Physicians Assistant). There is no question that Codeine (particular Empirin #4) was a drug of abuse at all times relevant hereto. It was placed in Schedule III of the controlled substance schedules in those years because of the common knowledge of its abuse potential.

XXXIII

In mitigation it is found that respondent Solof was the least culpable of the respondents: He is a young doctor who has attained a good reputation in the medical community for his skills in other contexts. He has completed more than is required in continuing medical education credits, and is Medical Director of Edgemont Hospital providing the medical services for that psychiatric hospital. He is Board Certified in Family Practice, and a Fellow of the American Academy of Family Practice. He is an owner of Victoria Medical Clinic (which is closed) and West Jefferson Medical Clinic. To his credit respondent refused to prescribe Quaalude, Amphetamines and Ritalin at Victoria.

While discipline must be taken against respondent Solof, it is believed that it is not necessary for the public health, safety, and welfare to restrict his personal drug dispensing privileges. His own personal prescription practices though not unimpeachable in 1977 through 1978, have apparently been tightened up, and were not so shocking as to require discontinuance.

He should, however, not be allowed to be a preceptor for, or supervisor of any Physicians Assistants for a period of time; should be required to take continuing education courses related to his conduct set forth herein; and to perform free public service during a period of probation.

There is no evidence of mitigation or rehabilitation regarding respondent Mellon.

XXXIV

The findings set forth hereinabove and established as true were found upon clear and convincing evidence to a reasonable certainty.

XXXV

Except as hereinabove found to be true, all other factual allegations of the Accusation, and assertions by the respondents are found to be unproved. Complainant's motion not to consider respondent's written argument was denied and said argument was fully considered.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

I

Cause exists to suspend or revoke respondent Mellon's license pursuant to Business and Professions Code Sections 2360 and 2361 in that he has committed acts constituting unprofessional conduct, as follows:

(1) For obtaining controlled substances by fraud and concealment, furnishing controlled substances to himself, giving false names and addresses on prescriptions and making false statements on prescriptions, all in violation of Sections 11170, 11173(a) and (b) and 11174 of the Health and Safety Code.

(2) For aiding and abetting the practice of medicine by unlicensed persons in violation of Sections 2141 and 2392 of the Business and Professions Code, and Sections 1399.522 of Title 16 of the California Administrative Code.

(3) For prescribing dangerous drugs without a good faith prior examination and medical indication therefor in violation of Section 2399.5 of the Business and Professions Code.

(4) For clearly excessive prescribing of drugs, repeated acts of clearly excessive prescribing of drugs, and repeated negligent acts in violation of Sections 2361.5, 725, and 2361(c) of the Business and Professions Code.

(5) For acts of dishonesty and deceit in violation of Sections 2361(d) and (f), 480(a)(2) and 2411 of the Business and Professions Code.

(6) For acts of gross negligence in violation of Section 2361(b) of the Business and Professions Code.

II

Cause exists to suspend or revoke respondent Solof's license pursuant to Business and Professions Code Sections 2360 and 2361 in that he has committed acts of unprofessional conduct as follows:

(1) For acts of gross negligence in violation of Section 2361(b) of said Code.

(2) For aiding and abetting the practice of medicine by unlicensed persons in violation of Sections 2141 and 2392 of said Code, and Section 1399.522 of Title 16 of the California Administrative Code.

(3) For prescribing dangerous drugs without a good faith prior examination and medical indicating therefor in violation of section 2399.5 of the Business and Professions Code.

(4) For clearly excessive prescribing of drugs, repeated acts of clearly excessive prescribing of drugs, and repeated negligent acts in violation of Sections 2361.5, 725, formerly section 700, and 2361(c) of said Code.

(5) For acts of dishonesty and deceit in violation of Sections 2361(d) and (f), 480(a)(2) and 2411 of said Code.

III

Cause does not exist to suspend or revoke the license of respondent Freibrun by reason of his death and the dismissal of the accusation as it pertains to him personally

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

I

The Accusation against respondent Jacob Louis Freibrun is dismissed.

II

The physician's and surgeon's certificate number A-030748, heretofore issued to respondent, Horace Milano Mellon, is hereby revoked as to each determination of issues set forth herein and as to all of them.

III

The physicain's and surgeon's certificate number G-29239, heretofore issued to respondent Barry Scott Solof, is hereby revoked as to each determination of issues set forth herein and as to all of them; provided, however, said revocations, and each of them, are hereby stayed for a period of five (5) years from and after the effective date of this order herein, and respondent is placed on probation for said period, upon the following terms and conditions:

1. Respondent shall comply with all laws of the United States, the State of California and its political subdivisions, and all rules and regulations of the Board of Medical Quality Assurance of the State of California.

2. Respondent shall report in person to the Division of Medical Quality or its agents or medical consultants at such meetings or interviews as may be directed during the period of probation.

3. Respondent shall submit to the Division of Medical Quality, at quarterly intervals, a declaration under penalty of perjury on forms provided by the Division, to the effect that he is fully and faithfully complying with all the terms and conditions of this probation. The first report shall be due when ordered by the Executive Director.

4. Respondent shall comply with the Division's probation surveillance program. In connection therewith, respondent shall make himself and/or any facility over which he has cognizance available for inspection by authorized representatives of the Division at any time for the purpose of verifying respondent's compliance with the terms of his probation.

5. In the event respondent should leave California to reside or to practice outside the State, respondent shall immediately

notify the Division, in writing, of the dates of departure and return. Periods of residency or practice outside California will not apply to the reduction of this probationary period.

6. Within sixty (60) days of the effective date of this decision, respondent shall submit to the Division for its prior approval a community service program in which respondent shall provide free medical services on a regular basis to a community or charitable facility or agency for at least thirty (30) hours a month for the first twenty-four (24) months of probation.

7. Within ninety (90) days of the effective date of this decision, respondent shall submit to the Division for its prior approval an education program related to Pharmacology, and Medical Therapeutics, and which shall not be less than 40 hours in length. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Said courses shall be completed within one (1) year of the date of approval of said program, by the Division.

Upon full compliance with the terms and conditions herein set forth and upon the expiration of the probationary period, the certificate shall be restored to its full privileges; provided, however, that in the event respondent violates or fails to comply with any of the terms and conditions hereof, the Board of Medical Quality Assurance, after notice to respondent and opportunity to be heard, may terminate this probation and reinstitute the revocations or make such other order modifying the terms of probation herein as it deems just and reasonable in its discretion.

I hereby submit the foregoing which constitutes my Proposed Decision in the above-entitled matter, as a result of the hearing had before me on the above dates, at Los Angeles, California, and recommend its adoption as the decision of the Board of Medical Quality Assurance.

DATED: 7 June 83

ROBERT A. NEHER
Administrative Law Judge
Office of Administrative Hearings

RAN:mh

REDACTED

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Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusations Against:	
BARRY SCOTT SOLOF, M.D. 2065 Outpost Drive Los Angeles, California 90068 Physician's and Surgeon's Certificate No. G-29239, and JACOB LOUIS FREIBRUN, M.D. 1016 Westholme Avenue Los Angeles, California 90024 Physician's and Surgeon's Certificate No. AO-6323, and HORACE MILANO MELLON, M.D. 401 West Manchester Boulevard Inglewood, California 90301 Physician's and Surgeon's Certificate No. A-030748, Respondents.	NO. D-2641 ACCUSATION

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COMES NOW complainant, Robert G. Rowland, who, as cause for disciplinary action against the above named respondents, charges and alleges as follows:

1. He is the Executive Director of the Board of Medical Quality Assurance (hereinafter referred to as the "board") and makes and files this accusation solely in his official capacity.

2. On or about May 9, 1975, the board issued to Barry Scott Solof, M.D. (hereinafter "respondent Solof") physician's and surgeon's certificate number G-29239. Said certificate is now, and was at all times mentioned herein, in full force and effect.

3. On or about August 30, 1933, the board issued to Jacob Louis Freibrun, M.D. (hereinafter "respondent Freibrun") physician's and surgeon's certificate number AO-6323. Said certificate is now, and was at all times mentioned herein, in full force and effect.

4. On or about February 17, 1977, the board issued to Horace Milano Mellon, M.D. (hereinafter "respondent Mellon") physician's and surgeon's certificate number A-30748. Said certificate is now, and was at all times mentioned herein, in full force and effect.

5. Section 2100 of the Business and Professions Code (hereinafter the "code") provides for the existence of the board as successor to the Board of Medical Examiners.

6. Section 2100.5 of the code provides for the existence of the Division of Medical Quality (hereinafter the "division") within the board.

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7. Section 2100.6 of the code provides, inter alia, that the division is responsible for reviewing the quality of medical practice in the state, the administration and hearing of disciplinary actions, and the carrying out of disciplinary action appropriate to findings made by a medical quality review committee, a hearing officer, or the division.

8. Sections 2360, 2361, and 2372 of the code provide that the division shall take disciplinary action against the holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct.

9. Section 2361, subdivision (b), of the code provides that unprofessional conduct includes but is not limited to gross negligence.

10. Section 2361, subdivision (d), of the code provides that unprofessional conduct includes but is not limited to incompetence.

11. Section 2361, subdivision (c),[1/] of the code provides that unprofessional conduct includes but is not limited to repeated negligent acts.

12. Section 725[2/] of the code provides that repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of

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1. Section 2361, subdivision (c), was added and the remaining subdivisions redesignated by Statutes 1976, chapter 1185, section 47, page 758.

2. Added by Statutes 1979, chapter 373, section 2, page ___, Statutes 1979, chapter 348, section 2, page _____.

diagnostic or treatment facilities as determined by the standard of the local community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist.

Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600) or by imprisonment for a term of not less than 60 days nor more than 180 days or by both such fine and imprisonment.

13. Section 700[3/] of the code provided, inter alia, during a portion of the times pertinent herein, that repeated acts of clearly excesive prescribing of drugs and repeated acts of clearly excessive use of treatment facilities as determined by the standard of the local community of licensees is unprofessional conduct.

14. Section 2361.5[4/] of the code provided, during a portion of the times pertinent herein, that clearly excessive prescribing or administering of drugs or treatment, use of diagnostic procedures, or use of diagnostic or treatment facilities which are detrimental to the patient, as determined by

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3. Section 700, added by Statutes 1977, chapter 509, section 1, page 1467, became effective January 1, 1978, and was repealed by both Statutes 1979, chapter 373, section 1, page _____, and Statutes 1979, chapter 348, section 1, page _____, effective January 1, 1979.

4. Section 2361.5, as amended by Statutes 1975, Second Extraordinary Session, chapter 1, section 16-5, page 3964, became effective December 12, 1975, and was repealed by Statutes 1977, chapter 509, page 1467, effective January 1, 1978.

the customary practice and standards of the local community of licensees, is unprofessional conduct within the meaning of chapter 5 (medicine) of division 2 (healing arts) of the code.

15. Section 2399.5 of the code provides, inter alia, that prescribing dangerous drugs as defined in section 4211, subdivision (k), of the code without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

16. Respondents Solof, Freibrun, and Mellon are subject to disciplinary action pursuant to sections 2360, 2361, and 2372 of the code within the meaning of section 2361, subdivisions (b), (c), and (d), sections 700, 725, 2361.5, and 2399.5 of the code in the manner of their treatment rendered to the following individuals as more particularly alleged hereinafter:

A. Patient GW[5/]

(1) Patient GW, a 55-year-old female, was first seen at Victoria Medical Group (hereinafter the "clinic") by respondent Solof on or about December 5, 1977. The presenting complaints were arthritis, nervousness, insomnia for one month, and chest cold with productive yellow sputum for one week. GW was treated at the clinic 10 times between December 1977 and July 1978, by respondents Solof, Freibrun, and Mellon.

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5. Names of all individuals identified herein by initials are available upon request for discovery.

(2) Respondent Solof's, Freibrun's, and Mellon's treatment of GW was inadequate in the following respects:

(a) On her first visit to the clinic on or about December 8, 1977, GW stated that she had had gall bladder surgery 20 years in the past but respondents failed to determine and/or record any particulars with respect to said surgery, including the nature and location thereof, and failed to obtain surgery and pathology reports with respect to said surgery. This constituted gross negligence and/or incompetence in light of the nature of GW's presenting and subsequent complaints and symptoms.

(b) On her second visit to the clinic on or about December 15, 1977, GW complained of pelvic pain and stated that she had had a hysterectomy in 1955. Respondents failed to obtain any documentation to establish the pathology for said surgery. This consituted gross negligence and/or incompetence.

(c) On her third visit to the clinic on or about January 10, 1978, GW was given a repeated pelvic examination including a papanicolau test and was given repeated electrocardiogram, urine analysis and culture and sensitivity testing although these tests had been performed previously on her first visit. Numerous examinations were performed over the course of GW's treatment by respondents without a defined rationale therfor. In spite of a reported estrogen effect as adequate or above normal on April 14 and 17, 1978, GW was given estrogen injections for "dysfunctional vaginal bleeding" or "hot flashes" on January 1, April 18, and May 2, 1978. The diagnosis of "dysfunctional vaginal bleeding" in a hysterectomized woman evidences gross negligence and/or incompetence and the repeated testing and estrogen injections with respect thereto constitute repeated acts of clearly excessive prescribing and/or

administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(d) As early as February 11, 1978, a urine analysis showed 11-20 WBC (white blood count) and 1-4 RBC (red blood count) on the high powered field. Urine culture and sensitivity tests were ordered repeatedly in the face of low WBC's and a shift to the right, which indicate a low probability of infection. It was not until July 12, 1978, that the source of the bleeding referenced hereinabove was found to be from the urinary tract and X-ray evidence of abnormal pelvic calcification on or about April 10, 1978, was ignored by respondents. Respondents' conduct in this regard constitutes gross negligence and/or incompetence and repeated acts of clearly excessive prescribing and/or administering of

drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(e) On or about July 19, 1978, GW was hospitalized at the clinic for gross hematuria. No cystoscopy was performed during GW's 3-day hospital stay and a sonogram and an intravenous pyelogram were ordered which resulted in a misleading diagnosis of polycystic kidney disease. This treatment pattern on the part of respondents constituted gross negligence and/or incompetence on the part of respondents and repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(f) During the month of September 1978, GW was hospitalized at the University of California at

Los Angeles. It was determined that she suffered from invasive adenocarcinoma and on September 26, 1978, she underwent a radical cystectomy, urethectomy, vaginectomy, ileostomy, and urinary diversion. Respondents were grossly negligent and/or incompetent in failing to diagnose malignancy in the case of GW. Respondents were further grossly ngeligent and/or incompetent in delaying said diagnosis of malignancy until August 22, 1978, through repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(g) Respondents were also grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of

clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 70% of GW's visits to the clinic, hypnotics on 60% of her visits, cough syrup containing codeine on 30% of her visits and antidepressants/tranquilizers on 30% of her visits which said prescription pattern was not medically indicated and was not based upon good faith prior examinations.

(h) The above said practices of respondents with respect to GW constitute repeated negligent acts and repeated acts of clearly excessive prescribing of drugs and repeated acts of clearly excessive use of treatment and diagnostic facilities as determined by the standard of the local community of licensees. The detrimental effect caused to GW thereby was the delay in diagnosing her extensive glandular cancer.

B. Patient FW

(1) Patient FW, a 29-year-old female, was first seen at the clinic by respondent Freibrun on or about September 10, 1976. Initial diagnoses of bronchitis and low back syndrome were made. FW was treated at the clinic by respondent Solof and respondent Freibrun on 28 visits during the period of November 23, 1976 through Novembr 10, 1977.

(2) Respondent Solof's and respondent Freibrun's treatment of FW was inadequate in the following respects:

(a) During at least the period of February 1977 through October 23, 1977, the date of delivery, FW was pregnant. During this period of time, FW made at least 15 visits to the clinic on which occasions she was treated by respondent Solof and/or respondent Freibrun. Respondent Solof and respondent Freibrun were grossly negligent and/or incompetent in failing to diagnose and/or make medical record notations as to FW's pregnancy.

(b) On or about April 7 and August 8, 1977, FW was prescribed

Tetracycline. On or about September 26, 1977, a Terramycin injection was given to FW and Tetracycline was again prescribed to be taken for 14 days. Respondents Solof and Freibrun were grossly negligent and/or incompetent in prescribing and/or administering and/or allowing to be prescribed and/or administered the above drugs to FW in that Tetracyclines cross the placenta, are found in fetal tissue and can have toxic effects on a developing fetus which are often related to retardation of skelatal development. Also, tooth development of the developing infant may be adversely affected. Respondents' actions in this regard constituted repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and or treatment procedures and/or facilities in a manner detrimental to the patient.

(c) On or about October 17, 1977, respondent prescribed or allowed to be prescribed for FW hydrochorothiazide. Such a routine prescription of a diuretic to an otherwise healthy pregnant woman, coming as it did less than a week before delivery, constituted gross negligence and/or incompetence in light of the countervailing possible hazard to the fetus including, but not limited to, neonatal jaundice and thrombocytopenia.

(d) On or about June 6, 1977, JW was given "The Last Chance" diet book by respondents. She was diagnosed as obese and instructed to continue her diet on a June 17, 1977, visit and again on a June 27, 1977, visit to the clinic. Respondents were grossly negligent and/or incompetent in misdiagnosing JW's pregnancy as obesity, in failing to consider the potentially serious complications indicated by complaints of water retention, misdiagnosed as a weight control and

not a pregnancy complication, and in failing to recognize backache complaints by JW as a common second trimester complication of pregnancy. In July and August, the sixth and seventh months of JW's pregnancy, she was also grossly negligently and/or incompetently diagnosed by respondents as obese and not pregnant.

(e) During the course of her treatment, JW was prescribed Empirin #4 on 82% of her visits to the clinic, hypnotics on 64% of her visits, cough syrup containing codeine on 82% of her visits and antidepressants/tranquilizers on 28% of her visits. During the course of the at least 15 visits during JW's pregnancy, respondents prescribed and/or administered or caused to be prescribed and/or administered the following drugs, the safe use of whcih during pregnancy has not been established:

(1) Preludin

(2) Actifed

(3) Biphetamine

(4) Fastin

(5) Dimetapp

The prescribing and/or administering of said drugs constituted on the part of respondents gross negligence and/or incompetence, repeated negligent acts, repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient, and the prescribing of dangerous drugs without a good faith prior examination and medical indication.

(f) Respondents were separately grossly negligent and/or incompetent in treating a pregnant woman for exogenous obesity, due to the known potentially teratogenic (relating to the development of monstrosities) and embryotoxic properties of the medication used, including, but not limited to, biphetamine.

C. Patient TR

(1) Patient TR, a 52-year-old male was first seen at the clinic on or about February 6, 1978. Treatment was supervised by respondents Solof and Freibrun. The presenting complaints were arthritis and insominia.

(2) Respondent Solof's and respondent Freibrun's treatment of TR was inadequate in the following respects:

(a) In taking the patient's past medical history, current illness was listed as none (sic). Assessed problems were anxiety neurosis, bronchitis, arthritis and prostatic hypertrophy. However, a chest X-ray taken on February 7, 1978, was interpreted by the radiologist as "severe congestive heart failure, or possibly early pulmonary edema. With the degree of cardiomegaly, however, I cannot rule out a pericardial effusion, although this is unlikely." An electrocardiogram was interpreted as ". . . left atrial enlargement; T wave abnormalities and possible

interventricle cardiac defect; first degree A-V block." Respondents were grossly negligent and/or incompetent in failing to obtain TR's past medical history in the face of the above referenced diagnostic tests which indicated severe heart problems.

(b) Respondent Solof and respondent Freibrun, in taking over the medical management of TR, were grossly negligent and/or incompetent in failing to determined that TR had been admitted to West Adams Community Hospital on at least seven occasions for severe heart difficulties as follows:

Date of Admission	Diagnosis
6/23/76 - 7/13/76	Congestive heart failure due to idiopathic cardiomyopathy.
8/6/76 - 8/16/76	Congestive heart failure.
9/9/76 - 9/24/76	Cardiomyopathy with congestive heart failure.
2/23/77 - 2/27/77	Right inguinal hernia. Congestive heart failure idiopathic cardiomyopathy.
4/13/77 - 4/15/77	Inguinal hernia. Lipoma spermaticord.
1/8/78 - 1/20/78	Refractory congestive heart failure. Probable idiopathic cardiomyopathy.

Date of Admission	Diagnosis
7/25/78 - 7/27/78	Acute myocardial infarction. Idiopathic cardiomyopathy. Intractable congestive heart failure.

(c) Respondent Solof and respondent Freibrun were grossly negligent and/or incompetent in failing to initiate an appropriate treatment regimen for TR's demonstrable physical ailments.

(d) During the course of his treatment, TR was prescribed Empirin #4 on all of his visits to the clinic, hypnotics on 77% of his visit, cough syrup containing codeine on 77% of his visits and antidepressants/tranquilizers on 66.6% of his visits. In light of the fact that TR was receiving treatment from another physician at Adams Community Hospital, as reflected hereinabove, respondents Solof and Freibrun were grossly negligent and/or incompetent in prescribing the above referenced drugs without closely coordinating their prescriptions and purported treatment with the physicians treating TR at Adams Community Hospital.

(e) The above said practices of respondents with respect to TR constitute

repeated negligent acts and repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient.

D. Patient MM

(1) Patient MM, a 41-year-old female, was first seen at the clinic on or about May 16, 1978. She was seen on follow-up visits on June 16, 1978, and July 17, 1978. Treatment was supervised by respondents Freibrun, Solof, and Mellon.

(2) Respondents' treatment of MM was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in making the diagnosis that MM was suffering from "acute bronchitis, rhinitis, anxiety neurosis and rule-out tension headaches and sinusitis" in that there were insufficient and/or inadequate tests conducted to substantiate these diagnoses.

(b) Respondents were grossly negligent and/or incompetent in failing to discover that MM was a diagnosed diabetic receiving Diabenese medication and suffering from glaucoma for which MM was receiving Isoptocarpine eye drops. The extensive testing performed on MM was such as to indicate that respondents had assumed responsibility for the medical management of MM and should reasonably have been able to determine MM's physical condition.

(c) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4, hypnotics, cough syrup containing codeine and antidepressants/tranquilizers on all

of MM's visits to the clinic which said prescriptions were not medically indicated and not based on good faith prior examinations.

E. Patient AB

(1) Patient AB, a 33-year-old female, was treated at the clinic on 18 separate visits between July 26, 1976, and June 14, 1978. Treatment was supervised by respondents Solof and Freibrun.

(2) Respondents' treatment of AB was inadequate in the following respects.

(a) Respondents were grossly negligent and/or incompetent in diagnosing AB as epileptic and suffering from migraine headaches on the basis of insufficient tests.

(b) Respondents were grossly negligent and/or incompetent in prescribing Triavil and Cafergot to AB in that Triavil and Cafergot are contraindicated to anyone who has a diagnosis of epilepsy.

(c) Respondents were grossly negligent and/or incompetent in failing to follow-up on subsequent visits an elevated white blood count

of 20,000 dated July 28, 1977, and an abnormal T-4 total protein, albumin and albumin globulin ratio dated June 28, 1976.

(d) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 77% of AB's visits to the clinic, hypnotics on 94% of her visits, cough syrup containing codeine on 22% of her visits and antidepressants/tranquilizers on 27% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

F. Patient JV

(1) Patient JV, a 26-year-old female, was treated at the clinic 28 times between September 29, 1977, and June 28, 1978. She

was originally seen complaining of injuries suffered as the result of an assault. Treatment was supervised by respondents Solof and Freibrun.

(2) Respondents' treatment of JV was inadequate in the following respects:

(a) Respondents caused blood chemistry testing to be performed on JV on July 29, 1977. Respondents were grossly negligent and/or incompetent in failing to document and/or determined the cause of a serum glutamic oxaloacetic transaminase test result of 155 when the normal range is 0-41; a serum glutamic pyruvic transaminase result of 319 when the normal range is 0-45; a lactic dehydrogenase result of 293 when the normal range is 60-200; and an alkaline phospatase result of 157 when the normal range is 30-115.

(b) Respondents were grossly negligent and/or incompetent in failing to thoroughly investigate JV's medical history of drug addiction in the context of the blood chemistry results referenced

hereinabove, elevated enzyme test results and the fact that respondents were prescribing for JV tranquilizers, barbiturates, hypnotics, and narcotics on a regular basis.

(d) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 75% of JV's visits to the clinic, hypnotics on 32% of her visits, cough syrup containing codeine on 42% of her visits and antidepressants/tranquilizers on 35% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

(e) Respondents were further grossly negligent and/or incompetent

after ingesting lye in June of 1975. LB had to be admitted to UCLA Medical Center on February 26, 1978, because of a stricture caused from said lye ingestion which said stricture was misdiagnosed by respondents on LB's visit to the clinic on February 24, 1978.

(b) Respondents were grossly negligent and/or incompetent in diagnosing insominia, bronchitis, anemia, and migraine headaches on the basis of insufficient jusitification therefor.

(c) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of LB's visits to the clinic, hypnotics on 88% of her visits, cough syrup containing

in engaging in the prescription practice referenced hereinabove in that between the dates of January 10 through 18, 1978, March 6 through 19, 1978, and April 20 through May 11, 1978, JV was undergoing treatment for drug detoxification and respondents should not have been dispensing narcotic, dangerous drugs to a patient undergoing drug detoxification.

G. Patient LB

(1) Patient LB, a 26-year-old female, was treated at the clinic nine times between January 3, 1978, and December 27, 1978. Treatment was supervised by respondent Solof and, less frequently, by respondents Freibrun and Mellon.

(2) Respondents' treatment of LB was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in that they failed to conduct an adequate physical examination of LB. An adequate examination would have developed the fact that LB had been treated for esophageal dilations

codeine on 77% of her visits and antidepressants/tranquilizers on 55% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

(d) Respondents were further grossly negligent and/or incompetent in engaging in the prescription practice referenced hereinabove in that as recently as May 3, 1976, LB had been hospitalized at West Valley Community Hospital for heroin detoxification with severe withdrawal symptoms and respondents Solof and Freibrun should not have been dispensing narcotic, dangerous drugs to a patient with a recent history of drug abuse under the above circumstances.

H. Patient AJ

(1) Patient AJ, a 41-year-old female, was treated at the clinic eight times between May 24, 1978, and February 7, 1979. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

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(2) Respondents' treatment of AJ was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to pursue possible problems presented by elevated alkaline phosphatase and lactic dehydrogenase test results obtained in May 1978 in repeatedly assessing low back syndrome but never evaluating same or implementing any treatment modality for same other than pain killing drugs and in ordering Indocin treatment in the absence of any objective evidence to substantiate any active stage of one of the disease entities for which Indocin should be used.

(b) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental

to the patient in prescribing Empirin #4 on all of AJ's visits to the clinic, hypnotics on 87% of her visits, cough syrup containing codeine on 87% of her visits and antidepressants/tranquilizers on all of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

I. Patient FR

(1) Patient FR, a 25-year-old female, was treated at the clinic six times between May 31, 1978, and November 9, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of FR was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to thoroughly investigate patient FR's constant complaints of menstrual cramps to rule-out a pathology with respect thereto.

(b) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly

excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of FR's visits to the clinic, hypnotics on all of her visits, cough syrup containing codeine on 33% of her visits and antidepressants/tranquilizers on 83% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

(c) Respondents were further grossly negligent and/or incompetent in engaging in the prescription practice referenced hereinabove in that as recently as January 1978, FR had received treatment at a drug detoxification center and respondents should not have been dispensing narcotic, dangerous drugs to a patient with a recent history of drug abuse under the above circumstances.

J. Patient DC

(1) Patient DC, a 29-year-old female, was treated at the clinic four times between April 10, 1978, and October 17, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of DC was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to take a complete medical history of DC and failing to document completely an adequate physical examination of DC.

(b) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of DC's visits to the clinic, hypnotics on all of her visits, cough syrup containing

first visit) are contraindicated in the case of a possible internal head injury.

(b) Respondents were grossly negligent and/or incompetent in that although BH continued to complain of headaches, complained of seizures and was diagnosed as having a post-concussion syndrome and seizure disorder on separate occasions, respondents Solof and Freibrun failed to have conducted any neurological examination, evaluation and/or consultation. BH had complained of dizziness and drowsiness and on her initial visit to the clinic had evidenced injuries to the head area.

(c) Respondents were grossly negligent and/or incompetent in failing to monitor and/or discuss a six-day hospitalization of BH at Monte Sano Hospital in January of 1978 and in failing to timely diagnose the perceived pneumonia which resulted in said hospitalization.

codeine on all of her visits and antidepressants/tranquilizers on 25% of her visits and, specifically, the drugs Indocin and Triavil, which said prescriptions were not medically indicated and not based on good faith prior examinations. Patient DC gave a history of taking no medication when she was first seen at the clinic.

K. Patient BH

(1) Patient BH, a 26-year-old female, was treated at the clinic 24 times between December 2, 1977, and November 10, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of BH was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in prescribing narcotic and hypnotic drugs for BH at a time when she was assessed as having post-concussion syndrome as a result of head concussion in that narcotic drugs, such as codeine in Empirin #4, and hypnotics (Tuinal was ordered on the

(d) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 76% of BH's visits to the clinic, hypnotics on 48% of her visits, cough syrup containing codeine on 24% of her visits and antidepressants/tranquilizers on 16%of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

L. Patient VB

(1) Patient VB, a 49-year-old female, was treated at the clinic four times between March 19, 1978, and May 19, 1978. Treatment was supervised by respondents Solof and Freibrun.

(2) Respondents' treatment of VB was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to obtain a complete medical history of VB and in failing to investigate the significance of laboratory tests which indicated elevated calcium, phosphorus, alkaline phosphatase, and triglycerides.

(b) Respondents were grossly negligent and/or incompetent in failing to obtain a complete medical history as an assessment of uncontrolled hypertension, in failing to treat or recommend treatment for said hypertension and in prescribing Actifed to VB, a drug which was marginally indicated otherwise and is contraindicated in cases of hypertension.

(c) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic

and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of VB's visits to the clinic, hypnotics on all of her visits, and cough syrup containing codeine on 75% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

M. Patient EM

(1) Patient EM, a 55-year-old male, was treated at the clinic 16 times between March 31, 1978, and February 6, 1979. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of EM was inadequate in the following respects:

(a) Respondents were grossly negligent in failing to medicate or treat EM for an assessment of uncontrolled hypertension, for failing to document adequately what treatment was rendered to EM and for prescribing medication for EM that is contraindicated in the case of hypertension.

(b) Respondents were grossly negligent and/or incompetent in failing to investigate and treat repeated complaints by EM of severe headaches.

(c) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of EM's visits to the clinic, hypnotics on 31% of his visits, cough syrup containing codeine on 18% of his visits and antidepressants/tranquilizers on 75% of his visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

N. Patient BJ

(1) Patient BJ, a 39-year-old male, was treated at the clinic 11 times between

August 29, 1977, and June 5, 1978. Treatment was supervised by respondents Solof and Freibrun.

(2) Respondents' treatment of BJ was inadequate in the following respect:

> Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of BJ's visits to the clinic, hypnotics on 91% of his visits and cough syrup containing codeine on 54% of his visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

O. Patient HR

(1) Patient HR, a 39-year-old female, was treated at the clinic eight times between November 10, 1977, and August 10, 1978. Treatment was supervised by respondents Solof and Freibrun.

(2) Respondents treatment of HR was inadequate in the following respect:

> Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient by prescribing for HR Indocin, Empirin with Codeine, Biphetamine, Butisol, and Tuinal, dependency producing medications, without medical indication, without a good faith prior examination and at a time when HR was undergoing drug detoxification.

P. Patient CE

(1) Patient CE, a 34-year-old female, was treated at the clinic 11 times between March 9, 1978, and October 2, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of CE was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent during the course of their treating CE on six separate occasions for various complaints in failing to determine that CE was pregnant. As a result of said gross negligence and/or incompetence, CE's pregnancy was not diagnosed for 16 weeks at which point in time a saline abortion was performed. Had the pregnancy been diagnosed earlier, a simpler, safer suction abortion could have been performed.

(b) Respondents were grossly negligent and/or incompetent in prescribing potentially teratogenic (having a tendency to produce the development of monstrosities) and embryotoxic drugs to CE at a time when she was pregnant.

(c) Respondents were grossly negligent and/or incompetent in failing to document and/or investigate a history of seizure disorder complained of by CE.

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(d) Respondents were grossly negligent and/or incompetent in prescribing penicillin and/or ampicillin (closely related to penicillin) for CE at a time when they knew or reasonably should have know that CE was allergic to penicillin.

(e) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 90% of CE's visits to the clinic, hypnotics on 81% of her visits, cough syrup containing codeine on 36% of her visits, and antidepressants/tranquilizers on 81% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

Q. Patient MW

(1) Patient MW, a 36-year-old female, was treated at the clinic eight times between November 18, 1977, and July 20, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of MW was inadequate in the following respect:

> Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on all of MW's visits to the clinic, hypnotics on all of her visits and cough syrup containing codeine on all of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

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R. Patient JC1

(1) Patient JC1, a 34-year-old female, was treated at the clinic 18 times between August 29, 1977, and May 25, 1978. Treatment was supervised by respondents Solof and Freibrun.

(2) Respondents' treatment of JC1 was inadequate in the following respect:

> Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 55% of JC1's visits to the clinic, hypnotics on 50% of her visits, cough syrup containing codeine on 33% of her visits, and antidepressants/tranquilizers on 27% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

Respondents were also grossly negligent and/or incompetent in ordering ampicillin for JC1 even though it was known that she gave a history of allergy to the closely related drug, penicillin.

S. Patient JC2

(1) Patient JC2, a 52-year-old female, was treated at the clinic 35 times between August 16, 1977, and August 9, 1978. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of JC2 was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to adequately evaluate and treat a diagnosis of hyperkalemia, a serious electrolyte imbalance, which leads to weakness and gastrointestinal symptoms and which can lead to cardiac arrest.

(b) Respondents were grossly negligent and/or incompetent in administering intravenous Talwin to JC2 at a time when JC2 had been diagnosed as suffering chronic

bronchitis and asthma in that Talwin may cause respiratory depression and should be used with caution in patients with bronchial asthma.

(c) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 91% of JC2's visits to the clinic, hypnotics on 31% of her visits, cough syrup containing codeine on 45% of her visits, and antidepressants/tranquilizers on 8% of her visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

T. Patient JG

(1) Patient JG, a 38-year-old male, was treated at the clinic 10 times between December 21, 1977, and September 28, 1978.

Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of JG was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to explore possible causes of laboratory studies indicating elevated alkaline phosphatase, serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, and triglycerides even though such elevated chemistries can represent such serious conditions as, but not limited to, myocardial infarction, skeletal muscle disease or liver disease.

(b) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing

Empirin #4 on all of JG's visits to the clinic, hypnotics on all of his visits and cough syrup containing codeine on all of his visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

U. Patient BA

(1) Patient BA, a 29-year-old male, was treated at the clinic 25 times between February 17, 1978, and January 23, 1979. Treatment was supervised by respondents Solof, Freibrun, and Mellon.

(2) Respondents' treatment of BA was inadequate in the following respects:

(a) Respondents were grossly negligent and/or incompetent in failing to attempt to discover possible causes of repeated complaints of low back pain and insomnia. Specifically, an inadequate medical history was taken, a rectal examination was not performed, and the opinion of an orthopedist was not solicited or obtained.

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(b) Respondents were grossly negligent and/or incompetent and committed repeated acts of clearly excessive prescribing and/or administering of drugs and/or treatment, and/or repeated acts of clearly excessive use of diagnostic and/or treatment procedures and/or facilities in a manner detrimental to the patient in prescribing Empirin #4 on 96% of BA's visits to the clinic, hypnotics on 32% of his visits and cough syrup containing codeine on 68% of his visits which said prescriptions were not medically indicated and not based on good faith prior examinations.

16. Section 2141 of the code provides, in pertinent part, that any person, who practices or attempts to practice any system or mode of treating the sick or afflicted in this state or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other mental or physical conditions of any person without having at the time of so doing a valid, unrevoked physician's and surgeon's certificate, or without being authorized to perform such act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a misdemeanor.

17. Section 2392 of the code provides, in pertinent part, that the employing, directly or indirectly, of any unlicensed practitioner in the practice of any system or mode of treating the sick or afflicted or the aiding or abetting of any unlicensed person to practice any system or mode of treating the sick or afflicted constitutes unprofessional conduct.

18. Section 1399.522 of title 16 of the California Administrative Code provides, inter alia, that a physician has continuing responsibility for supervising physician's assistants under his cognizance such that they are prevented from functioning autonomously.

19. Respondents Solof, Freibrun, and Mellon are further subject to disciplinary action pursuant to sections 2360, 2361, and 2372 of the code in that they are guilty of unprofessional conduct within the meaning of sections 2141 and 2392 of the code and section 1399.522 of title 16 of the California Administrative Code. The circumstances are as follows:

A. On or about January 22, 1979, one Leonard Washington, physician's assistant (hereinafter "Washington"), prescribed for Marlicia Voisard aka T[redacted] J[redacted] (hereinafter "Voisard") the controlled substances Placidyl and Tylenol with codeine.

B. On or about December 13, 1978, one Hunter Vassar, physician's assistant (hereinafter "Vassar"), prescribed for Voisard the controlled substance Amytal.

C. On or about February 5, 1979, Vassar, using the name of "Dr. Mellon," prescribed for Voisard the

controlled substances Carbrital and Tylenol with codeine.

D. Respondents Solof and Freibrun aided and abetted the unlicensed practice of medicine by employing Washington and Vassar and allowing them to prescribe the drugs Placidyl and Tylenol with codeine, Amytal and Carbrital which said prescription practice constituted the unlicensed practice of medicine.

E. Respondents Solof, Freibrun, and Mellon also allowed Washington and Vassar to routinely examine and prescribe for patients at the clinic which said practice constituted aiding and abetting the unlicensed practice of medicine by Washington and Vassar.

20. Section 2391 of the code provides, inter alia, that the prescribing, selling, furnishing, giving away or administering of controlled substances, narcotic and/or dangerous drugs to a habitue or addict constitutes unprofessional conduct.

21. Respondents Solof, Freibrun, and Mellon are further subject to disciplinary action pursuant to sections 2360, 2361, and 2372 of the code in that they are guilty of unprofessional conduct within the meaning of section 2391 of the code.

A. The allegations set forth hereinabove at paragraph 15, subparagraphs F, G, I, and O are incorporated herein by reference as though set forth at length.

B. In engaging in the prescription practices referenced hereinabove, respondents Solof, Freibrun, and

Mellon prescribed, furnished and/or administered and/or caused to be prescribed, furnished and/or administered controlled substances, narcotics and/or dangerous drugs to individuals who were habitues or addicts as evidenced by the fact of their undergoing or having recently undergone at the time of said prescriptions by respondents drug detoxification.

22. Section 2393 of the code provides, inter alia, that the use of a fictitious name without an unexpired, unsuspended, and unrevoked written permit from the division of licensing of the board constitutes unprofessional conduct.

23. Respondent Solof is further subject to discipline pursuant to sections 2360, 2361, and 2372 of the code in that he has been guilty of unprofessional conduct within the meaning of section 2393 of the code in that between the dates of February 1978 and February 1979, respondent Solof practiced medicine utilizing the name Victoria Medical Group, Inc., without a valid unexpired, unsuspended and unrevoked fictitious name permit from the board.

24. Section 2361, subdivision (d), of the code provides, in pertinent part, that unprofessional conduct includes, but is not limited to, the commission of any act involving dishonesty or corruption, whether the act is committed in the course of the individual's activities as a certificate holder, or otherwise, or whether the act is a felony or a misdemeanor.

25. Section 2361, subdivision (f), of the code provides, in pertinent part, that unprofessional conduct includes, but is

not limited to, any action or conduct which would have warranted the denial of the certificate.

26. Section 480, subdivision (a)(2), of the code provides, in pertinent part, that the board may deny a license on the grounds that the applicant has done any act involving dishonesty, fraud, or deceit with the intent to substantially benefit himself or another, or substantially injure another.

27. Section 2411 of the code provides, in pertinent part, that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts constitutes unprofessional conduct.

28. Respondents Solof, Freibrun, and Mellon are further subject to disciplinary action pursuant to sections 2360, 2361, and 2372 of the code in that they have been guilty of unprofessional conduct within the meaning of sections 2361, subdivision (e) and (f), 480, subdivision (a)(2), and 2411 of the code. The circumstances are as follows:

A. The allegations set forth hereinabove at paragraph 15 are incorporated herein by reference as though set forth at length.

B. Respondents Solof, Freibrun, and Mellon committed acts of dishonesty, corruption, fraud and/or deceit, evidenced by knowingly made and /or signed certificates and documents, in that they billed the California Medical Assistance Program ("Medi-Cal") for services rendered to the above set out patients and

collected monies with respect thereto when, in truth and in fact, said services were not rendered and were known by respondents Solof, Freibrun, and Mellon not to have been rendered.

29. Section 11170 of the Health and Safety Code provides that no person shall prescribe, administer or furnish a controlled substance for himself.

30. Section 11171 of the Health and Safety Code provides that no person shall prescribe, administer or furnish a controlled substance except under the conditions and in the manner provided by division 10 (Uniform Controlled Substances Act) of the Health and Safety Code.

31. Section 11172 of the Health and Safety Code provides that no person shall antedate or postdate a prescription.

32. Section 11173, subdivision (a), of the Health and Safety code provides that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances: (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of any material fact. Section 11173, subdivision (b), of the Health and Safety Code provides that no person shall make a false statement in any prescription, order, report, or record required by division 10 of the Health and Safety Code.

33. Section 11174 of the Health and Safety Code provides that no person shall, in connection with the prescribing, furnishing, administering, or dispensing of a controlled substance, give a false name or address.

34. Section 11175 of the Health and Safety Code provides that no person shall obtain or possess a prescription that does not comply with division 10 of the Health and Safety Code.

35. Section 11180 of the Health and Safety Code provides that no person shall obtain or possess a controlled substance by a prescription that does not comply with division 10 of the Health and Safety Code.

36. Respondent Mellon is further subject to disciplinary action pursuant to sections 2360, 2361, and 2372 of the code in that respondent Mellon has violated section 2399.5 of the code and sections 11170, 11171, 11172, 11173, 11174, 11175, and 11180 of the Health and Safety Code. The circumstances are as follows:

A. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of G[redacted] W[redacted]: 11/3/78 (#4686M30); 12/2/78 (#4686M42); 12/5/78 (#4686M44); 2/5/79 (#4686M56); 2/7/79 (#4686M59); 2/16/79 (#4686M62); 2/17/79 (#4686M63); 3/1/79 (#4686M68); 3/16/79 (#4686M75); and 3/27/79 (#4686M83).

B. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Preludin for an individual by the name of W[redacted] J[redacted]: 11/7/78 (#176954); 11/22/78 (#325629); 11/27/78 (#553858); 11/28/78 (#325780); 1/3/79 (#262437); 1/3/79 (#555003); 2/2/79 (#555810); 2/2/79 (#151381); 2/23/79 (#556441); 3/1/79 (#385093); 3/23/79 (#180434); 4/2/79 (#180756); 4/12/79 (#264877); 4/13/79

(#557874); 5/16/79 (#157376); 5/23/79 (#265893); 6/5/79 (#302617); 6/6/79 (#158319); 6/11/79 (#560505); 6/21/79 (#266618); 6/26/79 (#288028); 7/12/79 (#160343); 7/15/79 (#263869); and 8/21/79 (#306500).

C. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of I[redacted] G[redacted]: 11/8/78 (#4686M33); 12/4/78 (#4686M43); 1/4/79 (#4686M51); 1/5/79 (#4686M53); 2/2/79 (#4686M58); 2/23/79 (#4686M65); 3/23/79 (#4686M80); 4/15/79 (#4686M74); 4/10/79 (#4686M10); 4/24/79 (#4686M18); and 7/5/79 (#4308G55).

D. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of H[redacted] S[redacted]: 3/7/79 (#4686M70); 3/13/79 (#4686M73); 3/20/79 (#4686M77); 4/2/79 (#4686M86); 12/9/78 (#4686M46); 12/12/78 (#4686M47); 2/21/79 (#4686M64); and 4/20/79 (#4686M20).

E. On or about the following dates, respondent Mellon wrote prescriptions for the narcotic, dangerous drug Dilaudid for an individual by the name of D[redacted] M[redacted]: 11/24/78 (#4686M37); and 3/30/79 (#4686M12).

F. On or about the following date, respondent Mellon wrote a prescription for the narcotic, dangerous drug Dilaudid for an individual by the name of J[redacted] J[redacted]: 12/12/78 (#4686M47).

G. In truth and in fact, the above said prescriptions were written by respondent Mellon without a good faith prior examination and medical indication therefor in that the said prescriptions were neither intended for nor provided to the individuals in question but were used by respondent Mellon to divert the drugs in questions to respondent Mellon's own illegal use.

WHEREFORE, complainant prays that the division hold a hearing on the matters alleged herein, and following said hearing, issue a decision:

1. Suspending or revoking physician's and surgeon's certificate number G-29239 heretofore issued to Barry Scott Solof, M.D.;

2. Suspending or revoking physician's and surgeon's certificate number AO-6323 heretofore issued to Jacob Louis Freibrun, M.D.;

3. Suspending or revoking physician's and surgeon's certificate number A-030748 heretofore issued to Horace Milano Mellon, M.D.; and

4. Taking such other action as the division deems proper.

DATED: December 9, 1980

ROBERT G. ROWLAND
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

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STATE OF CALIFORNIA
STD. 113 (REV. 8-72)

OSP